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	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Healthcare Center	1205 8th Street Bakersfield, CA 93304

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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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop and implement a care plan for three of 22 sampled residents (Resident 9, Resident 56, and Resident 64): Resident 64's use of mind altering substances (Marijuana) substance while driving vehicle. This failure had the potential to put Resident 64, other residents, staff, and visitors at risk for accidents. 2. Resident 9's continued behavior of non-compliance. This failure had the potential for unmet care needs. 3. Resident 56 was on anti-viral medication. This failure had the potential for unmet care needs. Findings: 1. During a review of Resident 64's Minimum Data Set (MDS – an assessment tool), dated 10/1/25, the MDS indicated on section C (Cognitive Patterns), Resident 64 had a BIMS (Brief Interview for Mental Status) score of 13 (score of 13-15 means cognitively intact). The MDS indicated on section GG (Functional Abilities), Resident 64 had functional limitation in range of motion (limit to which a part of the body can be moved around a joint) on one side for both upper and lower extremities, was wheelchair-bound, was unable to walk, required supervision or touching assistance (helper provides verbal cues and/or touching assistance as resident completes the activity) with transferring to and from a bed to a chair or wheelchair, and required set up assistance (helper only assists prior to or following the activity) with wheeling himself using his wheelchair. During a review of Resident 64's MD [Medical Doctor] Progress Note (MDPN), dated 12/15/25, the MDPN indicated, patient [Resident 64] has a history of: Need for assistance with personal care, generalized muscle weakness. Comments: Supervision and care 24 hours. During a review of Resident 64's Behavior Note (BN), dated 1/12/26, the BN indicated, Resident [64] was seen sitting on his bed in his room preparing a marijuana cigar. During a review of Resident 64's BN, dated 1/20/26, the BN indicated, was reported by nursing that [Resident 64] was in his car all night, blocked entrance way and way [sic] playing loud music. Was asked to move car but refused till [sic] staff informed him it will be towed. During a concurrent observation and interview on 1/20/26 at 2:35 p.m. with Resident 64 in Resident 64's room, Resident 64 had dry dressing wrapped around his right foot. Resident 64 stated he had been going out of the facility and had been driving his car despite having amputation (surgically removed) of his right foot and smoking marijuana. During an interview on 1/20/26 at 2:51 p.m. with Social Services Director (SSD), SSD stated Resident 64 had been seen using marijuana in the facility and had been driving his car. SSD stated Resident 64 had almost hit several cars in the parking lot. (continued on next page)

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 - Few	During an interview on 1/20/26 at 3:30 p.m. with Director of Nursing (DON), DON stated Resident 64 had said he was driving his car. DON stated Resident 64 had been found to have marijuana on his bedside table. DON stated there was a concern for Resident 64's safety when he would go out and drive his car because of his substance use and unresolved surgical wound on his right foot. During a concurrent interview and record review on 1/20/26 at 3:45 p.m. with DON, Resident 1's Care Plan (CP), dated 1/20/26, was reviewed. There was no care plan developed to address Resident 64's use of illegal substance and driving his car. DON stated the facility don't know how to keep Resident 64 safe when driving his car. DON stated there should have been a care plan developed for Resident 64 to ensure his safety when using a mind altering substance and when driving his car. During a concurrent interview and record review on 1/26/26 at 11 a.m. with DON, the facility's policy and procedure (P&P) titled, Care Planning, dated 11/1/17, was reviewed. The P&P indicated, Purpose To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. The Care Plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs. DON stated P&P was not followed. 2. During a review of Resident 9's Medical Record (MR), [undated], the MR indicated Resident 9 went out with ex-wife on 5/6/25 and returned on 5/9/25. During a concurrent interview and record review on 1/29/26 at 3:10 p.m. with SSD, Resident 9's Care Plan, was reviewed. SSD was unable to provide evidence a care plan was developed and implemented for Resident 9's leaving facility without informing the staff. SSD stated there was no care plan written for non-compliance. 3. During a concurrent interview and record review on 1/29/26 at 2:30 p.m. with Infection Prevention Nurse (IP), Resident 56's Care Plan, was reviewed. IP was unable to provide evidence a care plan was developed and implemented for Resident 56's medication Cresemba (medication for fungal infection). During a review of Resident 56's Physician Orders (PO), dated 1/23/26, the PO indicated, Cresemba 186 milligram was started on 1/23/26 two capsules once time a day. During a review of the facility's policy and procedure (P&P) titled, Care Planning, dated 11/1/2017, the P&P indicated, To ensure that a comprehensive person-centered care plan is developed for each resident based on their individual assessed needs. Procedure. II. B. Any services that would be required, but are not provided due to the resident's exercise of rights, which includes the right to refuse treatment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview and record review, the facility failed to follow their policy and procedure (P&P) on:1. Out on Pass for one of three sampled residents (Resident 64) when Resident 64 was going out on pass without a physician order, and Resident 64 was not assessed by a licensed nurse prior to leaving out on pass and after coming back to the facility. These failures had the potential to jeopardize Resident 64's safety and had the potential for Resident 64 to receive delay in care. 2. Wound Management for one of two sampled residents (Resident 35) when Resident 35's gastrostomy tube (GT - small, soft tube placed through the skin directly into the stomach to deliver food, liquids, and medicine) site was not being treated as ordered by the physician and there was no care plan developed to manage Resident 35's skin irritation around the GT site. These failures had the potential to result in further skin breakdown.Findings:1. During a review of Resident 64's Minimum Data Set (MDS - an assessment tool), dated 10/1/25, the MDS indicated on section C (Cognitive Patterns), Resident 64 had a BIMS (Brief Interview for Mental Status) score of 13 (score of 13-15 means cognitively intact). The MDS indicated on section GG (Functional Abilities), Resident 64 had functional limitation in range of motion (limit to which a part of the body can be moved around a joint) on one side for both upper and lower extremities, was wheelchair-bound, was unable to walk, required supervision or touching assistance (helper provides verbal cues and/or touching assistance as resident completes the activity) with transferring to and from a bed to a chair or wheelchair, and required set up assistance (helper only assists prior to or following the activity) with wheeling himself using his wheelchair.During a review of Resident 64's MD [Medical Doctor] Progress Note (MDPN), dated 12/15/25, the MDPN indicated, patient has a history of: Need for assistance with personal care, generalized muscle weakness. Comments: Supervision and care 24 hours.During a review of Resident 64's Social Services Note (SSN), dated 1/9/26, the SSN indicated, [Resident 64] purchased a vehicle and is leaving the facility with out [sic] a MD out on pass.During a review of Resident 64's Order Summary Report (OSR), dated 1/21/26, the OSR indicated, Resident 64 did not have a physician order to go out on pass.During a review of Resident 64's RELEASE OF RESPONSIBILITY FOR LEAVE OF ABSENCE (RRLA - log for residents to sign when going out on pass and coming back to the facility), dated January 2026, the RRLA indicated:a. On 1/2/26, Resident 64 signed out on pass and did not sign when he came back to the facility.b. On 1/5/26, Resident 64 signed out on pass and did not sign when he came back to the facility.c. On 1/6/26, Resident 64 signed out on pass and did not sign when he came back to the facility.d. On 1/9/26, Resident 64 signed out on pass and did not sign when he came back to the facility.e. On 1/13/26, Resident 64 signed out on pass and did not sign when he came back to the facility.f. On 1/14/26, Resident 64 signed out on pass and did not sign when he came back to the facility.g. On 1/19/26, Resident 64 signed out on pass and did not sign when he came back to the facility.During a concurrent observation and interview on 1/20/26 at 2:35 p.m. with Resident 64 in Resident 64's room, Resident 64 had dry dressing wrapped around his right foot. Resident 64 stated he had all his toes amputated (surgically removed) on his right foot and his surgical wound on his right foot was still healing. Resident 64 stated he had been going out of the facility and had been driving his car.During an interview on 1/20/26 at 2:51 p.m. with Social Services Director (SSD), SSD stated Resident 64 had been seen using a mind-altering drug (marijuana) in the facility and had been driving his car. SSD stated Resident 64 had almost hit several cars in the parking lot. SSD stated when Resident 64 would go out on pass, he would not notify the licensed nurses, and the licensed nurses would not be able to notify the doctor until they found out during their rounds that Resident 64 had gone out.During an interview on 1/20/26 at 3:30 p.m. with Director of Nursing (DON), DON stated Resident 64 had said Resident (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	64 was driving his car. DON stated Resident 64 would leave out on pass anytime without telling the staff. DON stated the facility don't know how to monitor Resident 64 of his whereabouts. DON stated there was a concern for Resident 64's safety when he would go out and drive his car because of his mind-altering drug (marijuana) use and unresolved surgical wound on his right foot. DON stated Resident 64 did not have a physician order to go out on pass. DON stated Resident 64 should have had an authorization from the physician prior to going out on pass.During a concurrent interview and record review on 1/20/26 at 4 p.m. with DON, Resident 64's Nurses Note (NN), dated 1/13/26, was reviewed. The NN (written at 7:56 p.m.) indicated, Morning nurse reported to pm [evening shift] nurse that resident signed out around 2:35pm [sic] to go on pass out of facility during nurse rounds resident was seen heading out facility, during med [medication] pass resident have not returned back to facility. The NN (written at 9 p.m.) indicated, Resident returned back to facility. DON stated Resident 64 was not assessed prior to leaving the facility and coming back to the facility. DON stated the licensed nurses should have assessed Resident 64 when coming back to the facility for injuries and changes in mental status because the facility was aware Resident 64 was also using a mind-altering drug (marijuana).During a concurrent interview and record review on 1/26/26 at 11 a.m. with DON, the facility's P&P titled, Out on Pass, dated 11/1/17, was reviewed. The P&P indicated, It is the policy of the Facility to meet residents' physical and psychosocial needs to go out on pass. The Facility will make reasonable efforts to ensure the resident safety and uphold resident rights. If the Attending Physician and Psychiatrist (if applicable) determine that the resident may participate in activities outside the Facility, the Attending Physician will write/give an order for a pass on the physician order sheet. Prior to the resident leaving on pass, a Licensed Nurse will assess the resident's physical and mental status. When the resident returns to the Facility, a Licensed Nurse will re-assess the resident to determine the resident's condition and any medication returned after going out on pass, if applicable. The resident/responsible person will verbally notify a Licensed Nurse prior to going out on pass and will sign out and back in on Form A - Resident Out on Pass Log. DON stated the P&P was not followed. 2. During a review of Resident 35's Nurses admission Record (NAR), dated 1/19/26, the NAR indicated, G tube [GT] with skin irritation.During a concurrent interview and record review on 1/27/26 at 3:22 p.m. with Treatment Nurse (TN), Resident 35's Order Summary Report (OSR), dated 1/27/26, was reviewed. The OSR indicated, Cleanse GT site with NS [normal saline (used to clean wounds)], pat dry then apply zinc oxide [medicated cream used for wound treatment] to peri wound [skin surrounding a wound], cover with T-Drain sponge [white dry dressing, pre-cut absorbent pad used to keep the GT insertion site dry] then secure with tape Q [every] shift. Order Date. 01/19/2026. Resident 35's Treatment Administration Record (TAR), dated January 2026, was reviewed. The TAR indicated, the treatment order started on 1/19/26 for Resident 35's GT site was being done every day and evening shift. TN stated the OSR was not followed. TN stated the treatment order for Resident 35's GT site should have been done three times a day (every day, evening, and night shift) as ordered by the physician on 1/19/26. TN stated Resident 35's skin irritation around the GT site would get worse if the physician order was not followed. The OSR indicated, there was no physician order to monitor Resident 35's GT site as needed. TN stated there was no order to monitor Resident 35's GT site as needed if the dressing needed to be changed.During a concurrent observation and interview on 1/28/26 at 11:39 a.m. with TN in Resident 35's room, Resident 35's dressing on her GT site was black and did not cover the GT insertion site. Resident 35's GT site had redness and was leaking yellow liquid from the GT insertion site. TN stated Resident 35's dressing on her GT site was wet because there was GT formula (specially designed liquid, high-nutrient food meant to provide all necessary nutrition directly (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	into the stomach) leaking from the GT insertion site. TN stated the moisture around the GT site was causing irritation and redness on Resident 35's skin. TN stated Resident 35's GT site should have been monitored as needed to keep the GT site clean and dry. During an interview on 1/28/26 at 11:50 a.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated she saw Resident 35 on 1/28/26 around 10:30 a.m. and the dressing on Resident 35's GT site was black and did not cover the GT site. CNA 4 stated she did not notify TN or any licensed nurse about Resident 35's GT site. CNA 4 stated she should have notified the TN or any licensed nurse to change the dressing on Resident 35's GT site.During a concurrent interview and record review on 1/28/26 at 12:44 p.m. with DON, Resident 35's Care Plans (CP), dated 1/28/26, was reviewed. The CP indicated there was no care plan developed to address Resident 35's skin irritation on her GT site. DON stated Resident 35's skin irritation on her GT site was caused by the GT formula leaking from the GT insertion site. DON stated there should have been a care plan to monitor if the dressing on Resident 35's GT site needs to be changed to prevent further skin breakdown. DON stated CNA 1 should have notified a licensed nurse when the dressing on Resident 35's GT site needed to be changed.During a concurrent interview and record review on 1/28/26 at 12:44 p.m. with DON, the facility's P&P titled, Wound Management, dated 11/1/17, was reviewed. The P&P indicated, Purpose To provide a system for the treatment and management of residents with wounds including pressure and non-pressure ulcers. A Licensed Nurse will perform a skin assessment upon admission, readmission, weekly, and as needed for each resident. A Licensed Nurse will develop a Care Plan for the resident based on recommendations from Dietary, Rehabilitation and the Attending Physician. Per Attending Physician order, the Nursing Staff will initiate treatment and utilize interventions for pressure redistribution and wound management. DON stated the P&P was not followed.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to ensure a call system was available and functional for the residents in two of two sampled shower rooms. This failure had the potential to put the residents at risk for falls. Findings:During a concurrent observation and interview on 1/27/26 at 2:08 p.m. with Maintenance Supervisor (MS) in the shower room in station 3, the shower room did not have a call system present. MS stated there was no call system available for residents using the toilet and the shower in the shower room in station 3. MS stated there should have been an alternative call system provided for the residents using the toilet and the shower in the shower rooms.During a concurrent observation and interview on 1/27/26 at 2:15 p.m. with MS in the shower room in station 2, there was a black wireless call button with a bell logo hanging on the hand rail next to the toilet. MS pressed the black wireless call button. MS went to the nurses station 1 but there was no alarm heard from the shower room in station 2. MS stated there should have been an alarm heard at the nurses station 1 alerting the staff somebody needed assistance in the shower room in station 2. MS stated he would replace the black wireless call button in the shower rooms, but the black wireless call buttons would go missing. MS stated there should have been a functional call system available for the residents using the toilet and the shower in the shower rooms.During an interview on 1/28/26 at 12:44 p.m. with Director of Nursing (DON), DON stated the facility had two shower rooms (station 2 and station 3). DON stated the call system had not been working in the shower rooms and it had been an ongoing issue in the facility. DON stated there should have been an alternative call system available for the residents. DON stated Resident 85 and Resident 14 were using the toilet in the shower room in station 3. DON stated Resident 85 and Resident 14 were at risk for falls. DON stated if there was no call system in the shower rooms, it would put the residents at risk for accidents and falls.During a review of Resident 85's Morse Fall Scale (MFS), dated 12/9/25, the MFS indicated, Resident 85 had a score of 55 (score of 45 and higher means high risk for falls).During a review of Resident 14's Minimum Data Set (MDS - an assessment tool), dated 12/31/25, the MDS indicated, Resident 14 had a BIMS (Brief Interview for Mental Status) score of 6 (score of 0-7 means severe cognitive impairment).During a review of Resident 14's MFS, dated 12/31/25, the MFS indicated, Resident 14 had a score of 60.During an interview on 1/28/26 at 1:26 p.m. with Resident 14, Resident 14 stated he was able to control his bladder and would independently use the toilet in the shower room in station 3. Resident 14 stated there was no call system in the shower room.During a review of the facility's policy and procedure (P&P) titled, Communication - Call System, dated 11/1/17, the P&P indicated, Purpose To provide a mechanism for residents to promptly communicate with nursing staff. The Facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathing facilities. Should the primary call system become inoperable for any reason, the Facility shall provide a bell for each resident room. Call bells located within resident bathrooms are considered emergency calls due to the potential for falls and injury and must be answered promptly.