

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/23/2026
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: Follow their policy and procedure (P&P) titled, WanderGuard [sic] (device used as safety protocol used to assist staff in monitoring people at risk for wandering near exits) Policy and Procedure for one of three sampled residents (Resident 1) when Respiratory Therapist (RT) responded to Resident 1's wanderguard alarm but did not check outside the surrounding area to ensure Resident 1 did not exit the facility premises. Ensure the every 30-minute monitoring log were completed for one of three sampled residents (Resident 1) with a history of elopement (occurs when a resident leaves the facility without authorization and/or any necessary supervision). These failures resulted in Resident 1 leaving the facility unaccompanied, missing for approximately 15 hours, exposing Resident 1 to environmental dangers, and was found by the police department approximately 0.9 miles from the facility, lying on the ground deceased . Findings: During a review of the admission Record (AR), the AR indicated Resident 1 was [AGE] year-old, was admitted to the facility on [DATE] with diagnosis of muscle weakness, lack of coordination, unsteadiness on feet, difficulty in walking, Diabetes Mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) and dementia (a progressive state of decline in mental abilities). During a review of the facility's 5-day Report Investigation (RI) dated [DATE], the RI indicated, Resident 1 Elopement [DATE] 10:22 am per tv recording. reached up and turned the wander guard alarm off; immediately went out the door. (Resident 1) went directly to the locked gate and was able to open it and relocated the gate. When noted, missing 12 noon. (Resident 1) was found by the bpd (Police Department) . at 1:00 am [DATE]. currently awaiting the coroner's report for reason of death. During a review of the annual Minimum Data Set (MDS-resident assessment tool) dated [DATE], the MDS indicated Resident 1 had a BIMS (brief interview for mental status-cognitive screening) Summary Score of 9 (score of 8-12 means moderate impairment) and functional abilities: no functional limitations in upper and lower extremity range of motion, uses wheelchair for mobility. During a review of Resident 1's annual WANDERING RISK SCALE (WRS) assessment, dated [DATE], the assessment indicated Resident 1 cannot follow instructions, has a history of wandering, diagnosis of dementia, and has wandered in the past month. Resident 1's assessment score 13 (11 - above High Risk to Wander). During a review of Resident 1's Progress Notes PN, dated [DATE] (first elopement), the PN indicated, At routine rounds, resident (Resident 1) was noted to be absent from assigned location. The resident's (Resident 1) WanderGuard device was discovered at bedside, indicating the resident had exited without tracking device in place. The PN dated [DATE] (second elopement attempt) indicated, Resident 1 was seen leaving the facility. The PN dated [DATE] (third elopement attempt) indicated Front office staff noted alarm in the front going off. Resident (Resident 1) was walking his wheelchair out the door. During a review of Resident 1's Progress Notes (PN), (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 0689 Level of Harm - Actual harm Residents Affected - Few	dated [DATE] at 2:46 p.m., the PN indicated, 12 noon >[sic] visual monitoring check resident (Resident 1) not in his room or activities. This nurse check back patio, his bathroom and other places he usually goes. Code green (a facility response process to make staff aware of a missing resident) activated to check every room in the Facility. Police was phoned. During a review of Resident 1's PN, dated [DATE] at 6:55 p.m. the PN indicated, Resident still not at the facility, contacts on file called. who stated none of the family members have any information about him. All ERs (emergency room) were called and was not found in of [sic] of them. During a review of Resident 1's PN, dated [DATE] at 4 a.m., the PN indicated, Received call from (police department) around 0105 (1:05 a.m.), (police department) stated that they have found (Resident 1) deceased . Per (police department). ?Looks like he just layed [sic] down and passed away' (police department) stated they called here because Resident (1) had a wrist bracelet with our information on it.1. During an interview on [DATE] at 12:45 p.m. with Administrator, Administrator stated on [DATE] at 10:22 a.m., Resident 1 was seen on the facility surveillance camera of the front lobby leaving the facility. Administrator stated Resident 1 turned off the main entrance wanderguard alarm system, opened the front door, exited in his wheelchair, opened the outdoor gate, and left the facility perimeter unaccompanied. Administrator stated Resident 1 was found deceased by the police department on [DATE] at 1 a.m. (approximately 15 hours after Resident 1 left the facility) approximately 0.9 miles from the facility. During an interview on [DATE] at 1:39 p.m. with Administrator, Administrator stated on [DATE] at 10:22 a.m. Administrator stated RT was seen in the facility surveillance camera responding to the wanderguard alarm system. Administrator stated RT was seen walking to the front lobby and turning off the wanderguard alarm system. Administrator stated RT did not go outside the facility to look around to ensure no residents had exited the premises. Administrator stated when the wanderguard alarm system goes off, it was the staff responsibility to turned off the alarm system and look in the surrounding area including outside to look to see if there is any resident around. make sure they [residents] didn't go out. During an interview on [DATE] at 2:06 p.m. with RT, RT stated on [DATE] at approximately 10:30 a.m. he heard an alarm going off in the front lobby. RT stated he went to the front lobby, did not see any residents, turned off the alarm, and resumed working. RT stated he thought the alarm malfunctioned since there were no residents in the front lobby. RT stated he did not go outside to check the surrounding area to ensure no residents had already left the facility. During an interview on [DATE] at 2:26 p.m. with Certified Nursing Assistant (CNA 2), CNA 2 stated on [DATE] between 10 a.m. to 10:30 a.m. she was busy and did not hear the wanderguard alarm system go off. CNA 2 stated when responding to the alarm system, it was the responsibility of the staff to check all exit doors including checking outside the facility to make sure there is no one outside. During an interview on [DATE] at 2:44 p.m. with CNA 4, CNA 4 stated on [DATE] between 10 a.m. to 10:30 a.m. while she was in the shower room, she heard the wanderguard alarm system go off but was busy giving showers and did not respond to the alarm. CNA 4 stated when responding to the alarm system, it was important to check all surroundings including outside to ensure no residents had left the facility. During a review of the facility P&P titled, WanderGaurd [sic] Policy and Procedure adopted date [DATE], the P&P indicated, 3. Alarm Testing and response. Alarm Response: If the alarm sounds, staff immediately stop what they are doing and check to doors to ensure the residents have not left the safe area.2. During a review of Resident 1's Care Plan (CP) , dated [DATE], the CP indicated, (Resident 1) is at high risk for further attempts to wander/elope out of facility AEB(as evidenced by): Ambulates independently, exit seeking behaviors, propels wheelchair independently, verbalizes desire to leave the facility, episodes of wandering out off facility/elopement. Interventions dated [DATE] included: Frequent monitoring and diversion from exits. Provide consistent reminders to the resident (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	that he/she needs to stay in the facility unless they are accompanied by a staff or family members. Revised intervention dated [DATE] included: Monitor resident's whereabouts q (every) 30 minutes. During a record review of Resident 1's 30 MINUTES MONITORING Log, dated [DATE] through [DATE], the log indicated the following: On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: room, dining room, back patio, sleeping in room, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: room, hallway, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: hallway, back patio, backyard, sleeping in room, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: hallway, dining room, back patio, restroom, and sleeping in room, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: activities, dining, hallway, in room, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: hallway, in room, in bed, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: hallway, backyard, dining area, sleeping in room, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: dining, used restroom, in room, sleeping in bed, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: room, dining area, backyard patio, sleeping in room, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: hallway, backyard, dining room, and sleeping in room, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: in room, dining, in hallway, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: dining, hallway, back patio, sleeping in room, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: backyard, dining, hallway, sleeping in bed, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: hallway, dining hall, back patio, sleeping in bed, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: hallway, eating dinner in dining, watching tv in dining, back patio, sleeping in bed, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: outside, dining room dinner, in room, however CNAs did not document the times the observations were made. On [DATE] Night shift between 10:30 p.m. to 6 a.m. CNAs documented Resident 1's whereabouts, however no CNA signature was documented. On [DATE] Night shift between 10:30 p.m. to 6 a.m. CNAs documented Resident 1's whereabouts, however no CNA signature was documented. On [DATE] Night shift between 10:30 p.m. to 6 a.m. CNAs documented Resident 1's whereabouts, however no CNA signature was documented. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: hallway, (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	back patio, watching tv, dining area, sleeping room, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs were documenting Resident 1 was in the following areas: hallway, dining area, back patio, sleeping in bed, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: hallway, dining area, watching tv, back patio, sleeping room, however CNAs did not document the times the observations were made. On [DATE] PM shift between 2:30 p.m. to 11 p.m. CNAs documented Resident 1 was in the following areas: hallway, dining area, back patio, talking to roommates, sleeping in room, however CNAs did not document the times the observations were made. On [DATE] Night shift between 10:30 p.m. to 6 a.m. CNAs did not document Resident 1's whereabouts. On [DATE] AM shift between 6:30 a.m. to 2 p.m. CNA (CNA 1) documented at 9:30 a.m. Resident 1 was last seen in bedroom. No additional documentation on Resident 1's whereabouts after [DATE] at 9:30 a.m. During a concurrent interview and record review on [DATE] at 10:33 a.m. with Director of Nurses (DON), Resident 1's CP was reviewed. DON stated Resident 1 has a history of elopement. DON stated Resident 1 had first eloped on [DATE] (was missing for approximately 8 hours) and attempted to elope on [DATE] and [DATE]. On [DATE] Resident 1 was reassessed for WRS. DON stated Resident 1 remained a high risk for elopement and remained on every 30 minutes monitoring. During a concurrent interview and record review on [DATE] at 4 p.m. with DON, Resident 1's every 30 minutes monitoring log was reviewed from [DATE] through [DATE]. DON confirmed the 30 minutes monitoring log had missing documentation including, time, Resident 1's whereabouts and CNA signatures. DON stated Resident 1's whereabouts should have been monitored every 30 minutes, and the log should have been completed including time, and staff signatures. During an interview on [DATE] at 2:33 p.m. with CNA 3, CNA 3 stated Resident 1 was able to communicate his needs. CNA 3 stated Resident 1 was on every 30 minutes monitoring because He (Resident 1) tries to leave all the time. Sometimes he goes to the door, he has stuff packed and he tries to leave. During an interview on [DATE] at 3 p.m. with CNA 5, CNA 5 stated Resident 1 was high risk for elopement and required every 30 monitoring. CNA 5 stated, We keep an eye on him because he tries to leave. During an interview on [DATE] at 3:34 p.m. with CNA 1, CNA 1 stated she was assigned to Resident 1 on [DATE] on the day Resident 1 went missing. CNA 1 stated Resident 1 was on every 30 minutes monitoring due to he always tries to leave. CNA 1 stated she last documented seeing Resident 1 in his bedroom at 9:30 a.m. CNA 1 stated at 11 a.m. she was passing lunch tray, got to Resident 1's room and noted Resident 1 was not in his room. CNA 1 stated she did not see or document Resident 1's whereabouts at 10 a.m. or 10:30 a.m. During a review of The Weather Channel's monthly weather (TWCMW), dated [DATE], the TWCMW indicated the highest temperature on [DATE] was 101 degrees Fahrenheit (F), and lowest 75 degrees F. During a review of the Police report dated [DATE] at 3:17 p.m., the report indicated, On Saturday, [DATE], at approximately 12 p.m. (Resident 1 name) left the facility and went missing. On Sunday, [DATE], at approximately 12:38 a.m. (officer name) responded at the top of the bridge on the east side of the roadway, for a man down. During a review of Resident 1's Death Certificate dated [DATE], the certificate indicated Resident 1's probable cause of death was Myocardial Infarction (heart attack-happens when blood flow to the heart drops or stops). During a review of the facility's policy and procedure (P&P) titled, Wandering & Elopement, dated 11/17, the P&P indicated, The Facility will identify residents at risk for elopement and minimize any possible injury because of elopement. During a review of the facility's P & P titled, Elopement Risk Reduction Approaches, dated 11/17, the P&P indicated, I. Planning. D. Ensure that residents are able to move about freely, are monitored and remain safe. During a review of the facility's P&P titled, Care Planning, dated [DATE], the P&P (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	indicated, II. The Care Plan serves as a course of action where the resident (resident's family and/or guardian or other legally authorized representatives), resident's Attending Physician, and IDT work to help the resident move toward resident specific goals that address the resident's medical, nursing, mental and psychological needs. A comprehensive person-centered Care Plan will be developed for each resident. The Care Plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychological needs.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide a safe environment for two of three sampled residents with high risk for elopement (Resident 2 and Resident 3) when the south hallway alarm was not activated. This failure had the potential for Resident 2 and Resident 3 to elope. During an observation and interview on 7/6/25 at 1:54 p.m. with Licensed Vocational Nurse (LVN) in the facility's south hallway, the exit alarm did not alarmed when door was opened. LVN stated the exit alarm can only be turned off by a key and should be on at all times. During an interview on 7/6/26 at 2:40 p.m. with Administrator (Admin), Admin stated the exit door alarms should not be turned off. During an interview on 7/14/26 at 1:53 p.m. with Central Supply (CS), CS stated she disarms the exit alarm when she goes outside. CS stated she disarmed it on 7/6/26. During a review of the facility's P&P titled, Safety Committee - Composition and Duties, dated 11/1/17, the P&P indicated, Purpose To promote the quality of resident care and safety by monitoring safety practices. Procedure. Duties and Responsibilities may consist of, but are not limited to the following. B. Maintain Facility grounds in a manner to allow for the safety of residents. Identify unsafe work practices. G. Ensure that appropriate safety equipment and protective equipment is on hand and used as instructed.		

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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 ensure physician orders (PO) were followed for one of three sampled Residents (Resident 2) when Resident 2's Wanderguard band (system designed to help alert staff when residents wearing Wanderguard band are trying to exit facility) was used against manufactures instructions for proper usage. This failure had the potential for Resident 2 to leave the facility without staff being aware. During an observation on 7/6/26 at 2:14 p.m. in Resident 2's room. Resident 2 had the wanderguard wristband on her right ankle. During a review of Resident 2's PO, dated 11/4/25, the PO indicated, MONITOR PLACEMENT OF WANDEGURARD (RIGHT WRIST) QSHIFT (every shift). During a concurrent interview and record reviewed on 7/14/26 at 2:08 p.m. with Director of Nursing (DON), the Wanderguard Manufacture Instructions (WMI) were reviewed. The WMI indicated, Placement. Your Resident Wristband Transmitter may be placed on resident in several ways. Some key points to remember when placing wristband are: Place wristband wrist height, approximately three (3) feet off the ground. DON stated she is not sure why it was moved to Resident 2's ankle. DON stated it is important to follow manufacturer's instructions. DON reviewed Resident 1's and confirmed the wanderguard should be placed on Resident 1's right wrist. During a review of the facility's P&P titled, Physician Orders, dated 5/1/19, the P&P indicated, Purpose This will ensure that all physician orders are complete and accurate. Procedure. VIII. Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order.		