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

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately assess, develop, and implement interventions as well as implement the facility's policy and procedures (P&P) for one of 22 Residents (Resident 3) when: Resident 3 had nine falls with injuries between admission date (9/5/25) to hospitalization (12/1/25). These failures resulted in Resident 3 having two hospitalizations (11/3/25 & 12/1/25) with multiple injuries including skin tears, a fracture (broken bone) in the neck of left femur (top part of leg bone is broken), which required surgical intervention, and need for rehabilitation (action of restoring someone to health or normal life through training and therapy after illness).Resident 3 was not accurately assessed for skin conditions based on shower sheets and Braden scale (assess a resident's risk of developing pressure injury/sore/ulcer - [serious wound extending through the skin often presenting as a deep crater]) resulting in a facility acquired stage III pressure injury.Findings: During a review of Resident 3's admission RECORD (AR), dated 1/26/26, the AR indicated, Resident 3 was admitted on [DATE] with diagnosis of muscle weakness, unspecified dementia (relating to the mental processes of thinking, knowing, learning, and understanding), depression, anxiety disorder, lack of coordination and history of falling. During a review of Resident's 3 Brief Interview of Mental Status (BIMS - screening tool to assess cognitive function from scale 0-15 [intact 13-5, moderate 7-12, and severe 0-6]) dated 9/8/25, Resident 3's BIMS score was 6 (severe cognitive decline). During a review of Resident 3's Minimum Data Set (MDS) Assessment (a standardized assessment to evaluate a resident's functional abilities and healthcare needs), dated 9/6/25 the MDS section GG (Resident assessment tool to assess functional abilities and goals) indicated, Resident 3 required: A. Eating - Setup clean-up assistance B. Oral hygiene - Supervision or touching assistance (helper provides verbal cues and/or touching resident to complete activity) C. Toileting hygiene - Partial/moderate assistance (helper does less than half the effort) D. Shower/bathe self - Dependent (helper does all the effort) E. Upper body dressing- Supervision or Touching assistance F. Lower body dressing - Partial/moderate assistance (helper does less than half the effort) G. Put on/taking off footwear-Partial/moderate assistance H. Personal Hygiene - Partial/moderate assistance 1.During an observation on 1/26/26 at 9:23 a.m., in Resident 3's room, Resident 3 was lying flat in bed on a low pressure air mattress (mattress used to prevent wounds), holding two stuff animals, oriented to self, unable to identify how to call for assistance, and confused. During a concurrent interview and record review on 1/29/26 at 2:17 p.m. with Director of Nursing (DON), Resident 3's Interdisciplinary Team [IDT - group of professionals working together to achieve common focused patient goals] Fall, was reviewed. The following IDT dated 9/8/25-12/1/25 indicated: A. The IDT dated 9/8/25 indicated, Resident 3 had a fall on 9/7/25 at midnight. DON stated Resident 3 was found in the bathroom putting her pants back on and laying on the floor. DON stated interventions were to not leave Resident 3 unattended in bathroom and there were no other interventions initiated. B. The IDT dated 9/9/25 indicated, Resident 3 had a fall on 9/8/25 at 7:15 p.m. DON stated Resident 3 had been getting out of bed and fell on her left side. DON stated interventions were to put a fall mat on left side of bed and there were no other interventions initiated. C. The IDT dated 9/11/25 indicated, Resident 3 had a fall on 9/10/25 at 8:10 a.m. DON stated Resident was (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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

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 0684 Level of Harm - Actual harm Residents Affected - Few	found in her room, on her bottom on floor to the left side of the bed. DON stated interventions were to replace fall mat was with landing strips (a non slip material on the floor to assist with prevention of the fall) on left side and there were no other interventions initiated. DON stated Resident 3 acquired a skin tear on her left upper arm from the fall. D. The IDT dated 10/7/25 indicated, Resident 3 had a fall on 10/6/25 at 7 a.m. DON stated Resident 3 was found on her bottom in her room. DON stated interventions were to schedule a neurology (specialist of the brain) consult and had an appointment for December but was unable to go. DON stated there were no other interventions for Resident 3's fall. E. The IDT dated 10/8/25 indicated, Resident 3 had a fall on 10/7/25 at 2:20 a.m. DON stated Resident 3 acquired skin tears on her left and right elbow from the fall. DON stated new interventions were to keep overhead light on at all times during the night shift and there were no other interventions initiated. F. The IDT dated 11/3/25 indicated, Resident 3 had a fall on 11/3/25 at 10 a.m. DON stated Resident 3 was in her wheelchair and bent forward and fell to floor near the dining room. DON stated Resident 3 was sent to the emergency department but had no injuries. DON stated interventions were to have orthostatic blood pressures (the measurement of blood pressure [force of blood pushing against the wall of arteries] while sitting, standing and lying) monitoring weekly and there were no other interventions initiated. G. The IDT dated 11/5/25 indicated, Resident 3 had a fall on 11/4/25 at 4:30 a.m. DON stated Resident 3 was found in the hallway outside of her room and found on her knees. DON stated interventions were a referral to a psychiatrist (medical practitioner specializing in the diagnosis of mental illness) to review her medications. DON stated Resident 3 was seen the same day by the psychiatrist with no changes to her medications. DON stated there were no other (new) interventions initiated and nothing was changed regarding Resident 3's falls. H. The IDT dated 11/13/25 indicated, Resident 3 had a fall on 11/12/25 at 4 a.m. DON stated Resident 3 was found on her left side on her bottom, on the floor in her room. DON stated interventions were to place Resident 3 in a room closer to the nurses station and there were no other interventions initiated. I. The IDT dated 12/1/25 indicated, Resident 3 had a fall on 12/1/25 at 4:06 a.m. in Resident 3's room. DON stated Resident 3 had a lot of falls in the previous two months (9), and she did not like that Resident 3 was falling all the time. DON stated she had recommended Resident 3 to have a 1:1 (provides a dedicated staff member dedicated for one resident for complex medical needs) in the past (unspecified dates) to prevent further falls, but it was not approved (did not indicate who declined). There was no new intervention added after this fall. During a concurrent interview and record review on 1/29/26 at 3:10 p.m. with DON, Resident 3's Bowel and Bladder Program Screener (B&B - restorative nursing program designed to improve continence [the ability to control movement of the bowels and bladder] through scheduled toileting), dated 9/5/25 at 6:33 p.m. was reviewed. The B&B indicated, Resident 3 was a good candidate for retraining (learning a skill so job can be done differently). DON stated Resident 3 had a B&B score of 19 which would indicate a need for bowel and bladder training. DON stated a B&B retraining with care plans was not done and they should have been done to address Resident 3's falls. During a review of Resident 3's Change of Condition Evaluation (COC) dated 12/1/25 at 3:31 a.m., the COC indicated, Writer [not identified] was called to residents' [Resident 3] room by aide. Nurse found resident [3] sitting on floor on L [left] side of bed. ROM (range of motion) unable to complete d/t [due to] resident [3] not following instructions. C/o [complained of] hip pain at this time. Resident [3] unable to say why she wanted to get up. During a review of Resident 3's Acute Rehab Facility's admission H&P (AH&P-History and Physical), dated 12/6/25, the AH&P indicated, Resident 3 was female with medical history of. anxiety disorder, major depressive disorder. dementia, and wheelchair-bound over the past several months due to imbalance. The [Resident 3] is currently living at [Skilled Nursing Facility (SNF)] for the last four months. The [Resident 3] arrived to [Acute Hospital] after sustaining a ground-level fall. ED [emergency department] work up revealed a left femoral [thigh] fracture. The [Resident 3] is alert and oriented to name and DOB [DATE of birth] . On 12/2/25, the patient underwent open reduction and internal fixation [surgical procedure used to treat severe, displaced bone fracture that cannot heal properly (continued on next page)

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

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 0684 Level of Harm - Actual harm Residents Affected - Few	with casting alone and secure them using metal plates, screws, or rods] of left femoral neck fracture. Resident 3 required acute rehabilitation for 18 days (12/5/26-12/23/26) before being able to be safely discharged back to the facility.

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

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 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.

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

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe, sanitary and homelike environment for nine out of 22 residents (Resident 2, Resident 17, Resident 21, Resident 45, Resident 54, Resident 55, Resident 63, Resident 65, and Resident 72). This failure had the potential to increase risk for falls, effect resident dignity, and result in low self-esteem.Findings: During a concurrent observation and interview on 1/27/26 at 8:45 a.m. with Administrator and Maintenance Supervisor (MS) the following was found:1.Resident 2's room had a large 10 inch (in.) by 10 in. area of unpainted plaster located on the wall.2. The north wing shower room had a 12 in. by 12 in. area in the shower stall of slimy black textured dots on the ceiling. MS stated it was mold.3. Residents 17's room had a plastic container that held what appeared to be electrical or phone wires detached from the north wall of the room and exposed the contents. The wall under where the windows are located had a 16 in. by 16 in. area of loosened wall that moves with slight touch. Administrator stated it was possibly water damage.4. Residents 21's room had an air conditioning unit with a large ventilation tubing measuring approximately 12 in. in diameter running through the room window. The tubing was not secured and air from the outside was coming into the room.5. Residents 45's room had a large area about 13 in. by 13 in. of unpainted wall plaster. Next to the area of unpainted wall plaster was three large 20 in. scratches into the wall exposing the plaster.6. Resident 54's room had missing flooring approximately 15 in. in length upon entry into the room and missing flooring approximately 15 in. length prior to entering the restroom.7. Residents 55's room had missing blinds to the windows and a large 12 in. circular hole to the wall beneath the windows that cold air can be felt coming through.8. Residents 63's room had a 15 in. by 15 in. area on the wall in the middle of the room with unpainted plaster.9. Residents 65's room had a 40 in. by 40 in. area on the wall of exposed unpainted plaster. Approximately two feet away from the center window in the room is an area of missing flooring approximately 10 in. by 10 in. in measurement.10. Residents 72's room had a wall that was broken into pieces in a circular pattern approximately 12 in. in diameter. Above the circular broken wall was 24 in. scratches into the wall exposing the plaster. The floor beneath Res 72's bed had a 10 in. piece of flooring missing.Administrator stated the room findings, Needs to be addressed.During a review of the facility's policy and procedure (P&P) titled, Resident Rooms and Environment, dated 11/1/17, the P&P indicated, Purpose . To provide residents with a safe, clean, comfortable and home like environment. The Facility provides residents with safe, clean, comfortable, and homelike environment. Facility Staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. This shall include ensuring that residents can receive care and services safely and that the physical layout of the Facility maximizes resident independence and does not pose a safety risk.Facility staff aim to create a personalized, homelike atmosphere, paying close attention to the following . Cleanliness and order . comfortable levels of ventilation.

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

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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review the facility failed to have Certified Nursing Assistant (CNA)'s who have successfully completed either a nurse aide training or a competency evaluation program (is a structured and regulated process that measures an individual's knowledge, skills, and behaviors against establish job requirement) for three of three CNA's (CNA 1, CNA 2, and CNA 3). This failure resulted in CNA 1, CNA 2, and CNA 3 not be evaluated to determine if they were competent to provide resident care services.Findings:During a concurrent interview and record review on 1/28/26 at 10:07 a.m. with Director of Staff Development (DSD), CNA 1's personnel file (PF) was reviewed. DSD stated CNA 1 did not have the competency evaluation worksheet for onboarding completed. DSD stated CNA 1 did not have the competency evaluation for: hand hygiene, universal precaution (a set of infection control practices that require treating all human blood and certain body fluids for infection), isolation technique (method used to separate a specific component, organism, or variable from a mixed, contaminated, complex environment), and applying and removing Protected Personnel Equipment (PPE- a gear worn to minimize exposure) completed.During a concurrent interview and record review on 1/28/26 at 10:10 a.m. with DSD, CNA 2's PF was reviewed. DSD stated CNA 2 did not have the competency evaluation worksheet for onboarding completed. DSD stated CNA 2 did not have the competency evaluation for: hand hygiene, universal precaution, isolation technique, and applying and removing PPE completed.During a concurrent interview and record review on 1/28/26 at 10:15 a.m. with DSD, CNA 3's PF was reviewed. DSD stated CNA 3 did not have the competency evaluation worksheet for onboarding completed. DSD stated CNA 3 did not have the competency evaluation for: hand hygiene, universal precaution, isolation technique, and applying and removing PPE completed.During a review of the facility's policy and procedure (P&P) titled All Departments - New Employee Orientation, [undated], the P&P indicated, all newly hired employees receive a comprehensive New Employee Orientation prior to assuming independent job responsibilities.No employee may work independently until required orientation components are completed.Director of Staff Development (DSD) .Coordinates and conducts orientation .Maintains orientation and competency records .Maintains employee personnel file.E. Competency and Supervision .Competency validation required prior to independent work. During a review of the facility's P&P titled Job Description, undated, the P&P indicated, Title: Director of Staff Development (DSD).Implement and oversee the facility's in-service training program, ensuring compliance with state and federal training regulations. Provide hands-on training, skill validation, and competency assessment for all nursing staff.

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **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 Drug Disposition when two controlled medications were not accounted for on the facility's medication disposition form (document used to record the secure destruction or disposal of expired, discontinued or unwanted medication). This failure had the potential for abuse of controlled (highly, abusive) medication.Authenticate the medication for one of one sampled resident (Resident 56). This failure had the potential for Resident 56 to receive an unknown medication and not being monitored for side effects. Findings: During a concurrent interview and record review on [DATE] at 10:15 a.m. with Director of Nursing (DON), the controlled medications disposition forms undated, were reviewed. DON stated Ativan (benzodiazepine medication used to treat anxiety) oral concentration 2 milligrams (mg/milliliter [ml]) unopened 30 ml container, and lorazepam (benzodiazepine) 2 mg/ml with 7 ml left in container were not recorded on the medication disposition form. DON stated the process is when a controlled medication is discontinued or resident is discharged two licensed nurses will document the controlled medication on the medication disposition form with their signatures. DON stated the medication disposition form will include the medication name, prescription number, and signature of two licensed nurses. DON stated this process was not done for Ativan and lorazepam, and should have been done. During a review of the facility's (P&P) titled, Drug Disposition undated, the P&P indicated, Drugs discontinued by a physician order and outdated drugs that cannot be returned to the pharmacy for credit, can be returned for pharmacy proper disposal, are to be properly marked and disposed of in accordance with California's Medical Waste Management Act. Documentation of disposal is to be maintained. 3. Discontinued or outdated controlled drugs are to be delivered to the Director of Nursing for storage in an appropriately locked and secured storage area separate from other discontinued drugs until disposed properly according to policy and procedure. 4. Controlled drugs to be disposed and witnessed per facility policy. 5. All drugs disposed of or returned to the pharmacy for credit are to be entered onto an appropriate medication disposition record. 6. Information that must be entered into the records include a). RX Number b). Pharmacy Name c). Drug Name and Strength d). Quantity of Doses Remaining e). Resident's Name f). Date of Disposal. 7. Controlled drugs must be prepared for disposal by a registered nurse employed by the facility and a witness. Disposition of records for controlled drugs must include the information listed above and the signatures of both the nurse and the witness. 2.During a concurrent interview and record review on [DATE] at 2:30 p.m. with Infection Prevention Nurse (IP), Resident 56's Electronic Medical Record (EMR), [undated] was reviewed. The EMR indicated Resident 56 came back from hospital on [DATE] and there was no order for Cresemba (antifungal medication). IP stated the medication was brought in by family [unspecified]. IP stated the medication Cresemba was not sent to the pharmacy to validate the medication. During an interview on [DATE] at 4:23 p.m. with DON, the DON stated Cresemba was not verified with pharmacy. DON stated the facility staff [not specific] copied the order from the medication bottle on to the facility EMR without validating with pharmacy and dispensed it to Resident 56.

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

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on interview and record review the facility failed to implement their policy and procedure (P&P) titled DISHWASHING, when a facility dishwasher failed to reach the mandatory temperature to sanitize resident dishware and/or failed to document the temperature the dishwasher was reaching to ensure sanitation. This failure had the potential for a foodborne illness outbreak to occur resulting in harm up to and including death.Findings:During a concurrent interview and record review on 1/27/26 at 8:19 a.m. with Kitchen Supervisor (KS), the facility DISH MACHINE TEMPERATURE LOG (DMTL), was reviewed. KS stated the facility dish machine needs to reach a temperature of at least 120 degrees Fahrenheit (a unit of measurement) to sanitize resident dishware. KS stated the facility dish machine did not reach the temperature it should have to ensure sanitation of dishware on the following dates:June 30th there was no recorded temperature for the facility dish machine at dinner serviceAugust 28th there was no recorded temperature for the facility dish machine at dinner service. August 31st the facility dish machine was recorded to be at 100 degrees Fahrenheit at lunch service. August 31st there was no recorded temperature for the facility dish machine at dinner serviceOctober 17th, 21st, 22nd, 23rd, 28th and 29th 2025 the dish machine temperature was recorded to be at 100 degrees Fahrenheit for lunch serviceNovember 15th to the 30th 2025 (15 days total) the dish machine temperature was recorded to be at 100 degrees Fahrenheit for breakfast serviceKS stated he should have been made aware the facility dish machine was not reaching temperature, but he was not. KS stated if he was contacted about the facility dish machine not reaching temperature, he would have the dish machine serviced to fix the issue.During a review of the facility's Dish Machine Temperature Log (DMTL) dated 2023, the DMTL indicated, Please record wash and rinse temperatures . before each meal . Wash temperatures must be at least 120 (degrees Fahrenheit).During a review of the facility's policy and procedure (P&P) titled, DISHWASHING, undated, the P&P indicated, All dishes will be properly sanitized through the dishwasher. The dishwasher will be kept clean and in good working order. A temperature log . will be kept and maintained by the dishwashers to assure that the dish machine is working correctly. This log will be completed each meal prior to any dishwashing. If you cannot achieve the temperature, alert . Director or cook who will alert the Maintenance Department and stop washing dishes.

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

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to follow their policy and procedure (P&P) on Change of Condition Notification, for one of three sampled residents (Resident 53). This failure resulted in Resident 53 having unmet care needs for high blood pressure (force of blood pushing when your heart beat) and heart rate (the number of times when the hear beats per minute) which could result in damage to the heart, kidneys, brain, and result in heart attack.Findings:During a review of Resident 53's ADMISISON RECORD (AR), dated 12/9/25, the AR indicated, Resident 53 has a diagnosis of Atrial Fibrillation (AFib - is a common heart arrhythmia [abnormal heart beat] characterized by an irregular and often rapid heart rate and effect blood pressure) and Hypertensive heart disease without heart failure (structural and functional changes in the heart). During a review of Resident 53's Minimal Data Sheet (MDS - Resident assessment Tool), dated 12/12/25, the MDS indicated, Resident 53's Brief Interview for Mental Status (BIMS - cognition assessment tool, 15-point scale: 13-15 cognitively intact, 8-12 moderate impairment) score was 12.During an interview on 1/26/26 at 8:13 a.m. with Resident 53, Resident 53 stated she was considering going to the hospital a few days ago (unspecified date) because staff did not give her medication for AFib . Resident 53 stated she feels ill when she does not receive her AFib medication. Resident 53 stated it makes her feel scared when her heart rapidly beats and she doesn't know why the facility did not have her medication.During a review of Resident 53's Orders, dated 12/9/25, the Orders indicated, Resident 53 was prescribed Apixaban [blood thinner used to reduce the risk of blood clots in residents with AFib]) Oral Tablet 2.5 mg [milligram] give 1 tablet by mouth two times a day for A-Fib.During a review of Resident 53'3 Medication Administration Record (MAR), dated 1/1/26 -1/31/26, the MAR indicated, Monitor Vital Signs (assessment of blood pressure, heart rate, and breathing) Daily. The MAR indicated on 1/2/26 the vital signs indicated, Blood pressure (b/p) was 162/100 (normal is 120/60), Heart rate (HR) was 145 (normal is 60-100).During a concurrent interview and record review on 1/29/26 at 10:26 a.m. with Infectious Prevention Nurse (IP), Resident 53's medical record was reviewed. Resident 53's b/p on 1/2/25 at 9:07 a.m. was 147/100, and at 10:15 a.m. b/p was 148/100 with a HR of 145. IP stated the nurse should have rechecked Resident 53's vital signs but saw no documentation indicating that it was done. IP stated the facility practice is to re-check abnormal vital signs. During a concurrent interview and record review on 1/29/26 at 10:33 a.m. with IP, Resident 53's Progress notes (PN), were reviewed. Resident 53's PN indicated, Resident 53 was going to be sent to the hospital by the facility for high blood pressure but was not. Resident 53's hospital transfer got cancelled. IP stated the staff should have checked her vital signs and notified the physician but did not.During a review of the facility P&P titled, Vital Signs (VS), dated 11/1/17, the P&P indicated, Report abnormal or out of range vital signs promptly . the licensed nurse will assess the resident and notify the physician.notification interventions must be documented.During a review of the facility P&P titled, Change of Condition Notification (COC) dated 11/1/17, the P&P indicated, The licensed nurse will notify the residents attending physician when there is a.an accident involving the resident which.has the potential for requiring a physician intervention.a significant change in the residence physical mental or psychosocial status.clinical complicated.the licensed nurse will assess the residents change of condition and document the observation and symptoms.

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

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to have clear clinical justification to provide Zyprexa (a medication used to treat psychosis [mental state where you lose touch with reality, experiencing things that aren't real or hold strong false beliefs]) to one of 22 residents (Resident 82). This failure had the potential cause medication induced harm.Findings:During a review of Resident 82's admission RECORD (AR), dated 1/29/26, the AR indicated, Resident 82 was admitted to the facility on [DATE] with diagnosis of need for assistance with personal care, anxiety disorder (a mental health condition marked by excessive, persistent, and uncontrollable worry or fear), unspecified psychosis, and muscle weakness. During a review of Resident 82's Physician Order Sheet (POS), dated 1/6/26, the POS indicated, Resident 82 was to be on Zyprexa 5 mg (milligram) by mouth at bedtime for psychosis manifested by lack of motivation and trouble thinking. During a review of Resident 82's MEDICATION ADMINISTRATION RECORD (MAR), dated January 2026, the MAR indicated, Resident 82 received Zyprexa 5 mg at 9 p.m. on 1/6/26 to 1/28/26 (22 days). Under the section Monitor for number of episodes of lack of motivation and trouble thinking every shift, Resident 82 had no documented behavior episodes for the month of January 2026. During a concurrent interview and record review on 1/29/26 at 9:37 a.m. with Social Services Director (SSD), Resident 82's Electronic Health Record (EHR) was reviewed. SSD stated Resident 82 was admitted to the facility on [DATE] with a prescription for Zyprexa 5 mg. SSD stated on 7/29/24 Resident 82's order for Zyprexa was ordered to be discontinued as it was no longer needed. SSD stated Resident 82 went to the acute hospital on 1/4/26 and returned to the facility on 1/6/26 and the acute hospital may have mistakenly restarted Resident 82's Zyprexa 5 mg. SSD stated at the facility Resident 82's Zyprexa 5 mg was continued per the hospital order but there was no IDT (Interdisciplinary team - a team of professionals that meet to discuss resident safety, treatment, and goals) to discuss if the Zyprexa order should have been continued and if there was clinical justification for Resident 82 to take the Zyprexa. SSD stated there were no alternative treatments trialed prior to placing Resident 82 back on Zyprexa (the IDT would have discussed this) nor was a care plan (a written, personalized roadmap for a person's health, safety, and daily support needs, created by doctors, caregivers, and the individual) created.During an interview on 1/29/26 at 10:36 a.m. with Director of Nursing (DON), DON stated, the IDT did not meet for Resident 82 new order of Zyprexa 5 mg. DON stated the IDT should have met to discuss the appropriateness of the new order for Zyprexa and see if there was clinical justification. During a review of the facility's policy and procedure (P&P) titled, Psychotherapeutic Drug Management, dated 11/1/17, the P&P indicated, Purpose . To implement the most desirable and effective interventions to change, modify, decrease, or eliminate behaviors that are distressing to the resident, and/or are decreasing or negatively impacting the residents' quality of life. To ensure the resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition(s). To ensure non-pharmacological interventions are considered and used when indicated, instead of, or in addition to, medication. To ensure clinically significant adverse consequences are minimized. The IDT, in consultation with the Consulting Pharmacist and the resident's Attending Physician . will discuss the psychotherapeutic medications at least quarterly, or as needed. Interdisciplinary Team (IDT) Responsibility . The care plan will reflect an individualized team approach emphasizing person-centered interventions with measurable goals, timetables and specific interventions. The resident's Care Plan will include the reason(s) for the drug and describe the behaviors the drug was prescribed to treat. The IDT note will include: reasons for the drug, manifestations for the drug, an analysis of the residents response to the drug and response to psychiatric consult or recommendations . new non-drug interventions and reasons for continuing same dose, decreasing dose and/or increasing dose.

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

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the facility's policy and procedure (P&P) titled Unusual Occurrence Reporting, for one of 22 sampled residents (Resident 3) when the facility did not report to the California Department of Public Health (CDPH) Resident 3's fall with injury (fracture [broken bone] of left leg) with subsequent hospitalization, need for surgical intervention, and rehabilitation. This failure resulted in the facility not reporting to CDPH and resulted in a lack of investigation. Findings:During a review of Resident 3's admission RECORD (AR), dated 1/26/26, the AR indicated, Resident 3 was admitted on [DATE] with diagnosis of muscle weakness, unspecified dementia (cognitive decline), depression, anxiety disorder, lack of coordination and history of falling.During a review of Resident 3's Change of Condition Evaluation (COC), dated 12/1/15, the COC indicated, at 3:31 a.m. Writer was called to residents' room by aide. Nurse found resident [3] sitting on floor on L [left] side of bed. ROM (range of motion) unable to complete d/t [due to] resident [3] not following instructions. C/o [complained of] hip pain at this time. Resident [3] unable to say why she wanted to get up.During a review of Resident 3's :admission H&P (AHP), dated 12/6/25, the AHP indicated, on 12/1/25 Resident 3 had a fall at the facility that resulted in left leg fracture. On 12/2/25 Resident 3 had surgery to correct the left leg fracture. During a concurrent interview and record review on 1/29/26 at 12:03 p.m. with Director of Nursing (DON), Resident 3's electronic health record (EHR) was reviewed. DON stated Resident 3 had a fall on 12/1/25 and was sent to acute hospital (12/1 thru 12/5/25) status post fall and pain in left hip. DON stated she was not aware of Resident 3's left leg fracture (12/1/25) until she reviewed the EHR today (1/29/26). DON stated she did not follow up on Resident 3's fall and report the incident as she had been unaware of Resident 3's fall with a fracture.During an interview on 1/29/26 at 2:17 p.m., with DON, DON stated Resident 3's fall with a femoral fracture was an unusual occurrence and should have been reported to the CDPH according to their policy.During a review of the facility's P&P titled, Unusual Occurrence Reporting, dated November 2017, the P&P indicated, Purpose. To ensure that timely reports are made to designated agencies as required by state and federal law. 1. The facility reports the following events by phone and in writing to the appropriate Sate or Federal agencies . III. Unusual occurrence are reported to the appropriate agency within 24 hours by telephone and then confirmed in writing.

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

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 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. 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 (continued on next page)

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

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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

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 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 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 (continued on next page)

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

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review, the facility failed to provide the individualized activities services for one of 22 sampled residents (Resident 97). This failure had the potential for Resident 97 to have diminished functional needs to promote maximum participation in activities. Findings:During an observation on 1/26/26 at 9:15 a.m. in Resident 97's room, Resident 97 was lying in bed staring at the walls. During an interview on 1/26/26 at 2:39 p.m. with Family Member (FM) 1, FM 1 stated, Resident 97 is in bed all the time. FM 1 stated he had requested activities to be provided to Resident 97 in the room because FM 1 feels that Resident 97 is depressed. During a review of Resident's 97's admission RECORD (AR), dated 11/15/25, the AR indicated, Resident 97 had muscle weakness, lack of coordination, and assistance with personal care.During a review of Resident 97's Care Plan (CP) Activities, [undated], the CP indicated, Resident 97 goal is, express satisfaction with type of activities and level of activity involvement when asked.During a concurrent interview and record review on 1/26/26 at 9:26 a.m. with Activities Director (AD), Resident 97's IN ROOM VISITS ACTIVTY RECORD (IRVAR) was reviewed, the IRVAR indicated, on 1/1/26 transfer to the hospital1/2/26 transfer to the hospital1/4/26 family visit1/5/26 slept1/7/26 Not Applicable1/9/26 family visit1/11/26 family visit1/19/26 Not Applicable1/21/26 CNA attending to him1/23/26 Not Applicable1/25/23 Family Visit1/27/26 SleptAD stated that Resident 97's activities is for one hour on Monday's, Wednesday's and Fridays. AD can't verify that staff attempted other times to involve Resident 97 in activities when family was present during the hour, when Resident 97 was sleeping, or when Resident 97 was being attended by a Certified Nursing Assistant (CNA). AD could not identify what Not Applicable meant. AD had no other log that attempted Resident 97 in activities or what activities were being presented to Resident 97 for participation. During a review of the facility's policy and procedure (P&P) titled, Room Visit Program, dated 4/1/21, the P&P indicated, The Facility will provide recreational opportunities for residents who are not physically able to or choose not to leave their room. Residents who prefer not to, or cannot, participate will be visited in their room on a regular scheduled basis.Room activities may include games, discussions, arts and crafts, and sensory stimulations, reading or educational programs, or adapted exercise.Activity staff will maintain a record of the activities provided for each resident when visited in the room.activities staff will document the activity the level of participation and response to the approach will be recorded.

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

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to give one of 22 sampled residents (Resident 35) oxygen per the physicians' orders. This failure had the potential for hypoxia (insufficient oxygen reaching body tissues to maintain normal function causing shortness of breath, confusion, rapid heart rate, bluish skin, and other negative outcomes up to and including death).Findings:During a review of Resident 1's admission RECORD (AR), dated 1/29/26, the AR indicated, Resident 35 was admitted to the facility on [DATE] with diagnosis of muscle weakness, need for assistance with personal care, hypertensive heart disease (damage to the heart muscle, valves, or blood vessels caused by long-term high blood pressure [measures the pressure your blood is pushing when the heart beats] with heart failure (the heart can't pump enough oxygen-rich blood to meet the body's needs), acute (severe, sudden) on chronic (persistent long lasting condition) combined systolic (blood pressure when the heart is at work) and diastolic (blood pressure when the heart is at rest) heart failure. During a review of Resident 35's Physician order sheet (POS), dated 1/25/26, the POS indicated, Resident 35 was ordered by the physician to be on oxygen two liters (a unit of measurement) via nasal cannula (nc - a lightweight, flexible tube worn around the ears inserted into the nostrils to deliver supplemental oxygen) as needed for shortness of breath.During a concurrent observation and interview on 1/26/26 at 8:48 a.m. with Treatment Nurse (TN), in Resident 35's room, Resident 35 was observed lying in bed with oxygen being delivered via nc. TN observed the oxygen setting and stated it was at 1 liter not two liters of oxygen as ordered for her shortness of breath. 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 and provide oxygen to the tissues. A physician's order is required to initiate oxygen therapy, except in an emergency situation. The order shall include . oxygen flow rate . procedure . check the physician's order . Turn on the oxygen at the prescribed rate.

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

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three of 22 sampled residents (Resident 98, Resident 97, and Resident 35) had staff with skills (specific abilities to perform their job) and competency (knowledge, skills, abilities, and behaviors) to provide care and services when: 1.Registered Nurses (RN 1, RN 2, RN 3, RN 4, RN 5, and Director of Nursing [DON]) were not competent to provide TPN (total parenteral nutrition - is a method of delivering all essential nutrients-such as protein, carbohydrates, fats, vitamins, and minerals-directly into the bloodstream through an PICC (a long, this, flexible tube inserted into a vein in the upper arm and threaded into a large vein near the heart) line for two of two sampled residents (Resident 98 and Resident 97). This failure had the potential for TPN associated negative outcomes up to and including death. 2. Certified Nursing Assistants (CNA 1, CNA 2, and CNA 3) were not competent to provide direct care to residents that included: hand hygiene, bed making, infection control measures, clean and dirty linen handling, Activities of a Daily Living (ADLs -everyday task people do to live independently which includes bathing, dressing, eating, using the toilet, and moving around), razor disposal, cleaning/storing bed pans and urinals, feeding residents. This failure had the potential for all residents to be exposed to negligent care and compromised safety. 3. Five of Five sampled RN's (RN 1, RN 2, RN3, RN 4, and RN 5) were not competent to provide Dialysis (a medical treatment that removes waste products and excess fluid from the blood when the kidneys are no longer able to perform these functions naturally) Catheter Care (an access point created surgically for patients undergoing dialysis). This failure had the potential for Dialysis Catheter Care negative outcomes such as infection, up to and including death to occur. Findings: 1. During a review of Resident 98's admission RECORD (AR), dated 1/29/26, the AR indicated, Resident 98 was admitted to the facility on [DATE] with diagnosis of muscle weakness, need for assistance with personal care, colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body), mild protein-calorie malnutrition (a nutritional state from insufficient protein and energy, showing subtle signs like fatigue, recurrent infections, or losing some weight/muscle/fat), electrolyte and fluid imbalance (a condition where the body's water levels and essential minerals like sodium, potassium, calcium, and magnesium are too high or too low, disrupting normal, vital functions), and disorder of plasma-protein metabolism (a condition in which is characterized by the faulty production, processing, or regulation of proteins in the blood). During a review of Resident 98's Physicians Order Sheet (POS), dated 1/23/26, the POS indicated, Resident 98 was to be placed on TPN at 50 ml (milliliter) an hour (hr) for one hour then increase to 100 ml/hr for 14 hours then decrease back to 50 ml/hr for one hour then stop. Repeat every night. 500 ml 20% (percent) lipid (fatty compounds that perform a variety of functions in your body) four times a week (Monday, Wednesday, Friday, and Sunday) infused separately, one time a day. During a review of Resident 98's Care Plan Report (CP), dated 1/26/26, the CP indicated, Resident 98 has nutritional problems or potential for nutritional problems related to taking TPN. The interventions listed on the CP indicated to provide TPN as ordered by the physician. During a review of Resident 98's IV MAR (Intravenous Medication administration record) (IVMAR), dated January 2026, the IVMAR indicated, Resident 98 received TPN on 1/24/26, 1/25/26, 1/27/26, and 1/28/26. (continued on next page)

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

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/28/26 at 2:48 p.m. with Director of Nursing (DON), the facility staff competencies were reviewed. DON stated five RN's (RN 1, RN 2, RN 3, RN 4, RN 5) and DON provided Resident 98 with IV TPN. DON stated there were no competency test or assessments done on the facility RNs including herself (DON) to show that they are competent in providing TPN care. DON stated RN 1 had previous experience with TPN and verbally instructed the other RNs on how to provide TPN to Resident 98. DON stated there was no documented proof that RN 1 provided appropriate competency training on TPN to the RN's. During an interview on 1/28/26 at 3:03 p.m. with RN 1, RN 1 stated, he taught RN 2, RN 3, RN 4, RN 5, and DON how to provide TPN to Resident 98. RN 1 stated he had no documented proof that he provided the TPN education. RN 1 stated the experience he had with providing TPN was when he was out of the country in 2022 and had a patient (resident) that required it. RN 1 stated he had no other experience with giving TPN to residents or educating other staff on how to safely provide TPN. During a review of Resident 97's Care Plan (CP), dated 11/17/25, the CP indicated, Administer TPN daily X 24 Hours. Access PICC line for S/SX [signs and symptoms] of infection infiltration. During a review of Residents 97's POS, dated 12/7/25, the POS indicated, MIX EACH BAG WITH 10ml [milliliters] INFUVITE [daily multivitamin maintenance supplement] (BLUE AND WHITE), THEN INFUSE 1 IV BAG VIA IV PUMP AS FOLLOWING: 77 ML/HR X 24 HOURS/DAY, (1560ML CLINIMIX 5%-20%, 250ML INTRALIPIDS 20%, 5ML STERILE WATER) ELECTROYLTES: 1ML TRACE ELEMENTS. EVERY 24 HOURS FOR TPN. During a review of Resident 97's IVMAR, dated 11/25, the IVMAR indicated, Resident 97 received the TPN on the following days; 11/16/25, 11/17/25, 11/18/25, 11/19/25, 11/21/25, 11/22/25,11/23/25,11/25/25,11/26/25, 11/27/25,11/28/25,11/29/25.11/30/25. During a review of Resident 97's IVMAR, dated 12/25, the IV MAR indicated, Resident 97 received the TPN on the following days;12/1/25, 12/2/25, 12/3/25,12/4/25,12/5/25,12/6/25,12/7/25,12/8/25,12/9/25,12/10/25,12/11/25,12/12/25,12/13/25,12/14/25,12/15 During an interview on 1/29/26 at 9.44 a.m., with DON, DON stated there was no training for PICC Line or TPN prior to Resident 97's receiving TPN. During a review of the facility's policy and procedure (P&P) titled Total Parenteral Nutrition, dated 11/1/17, the P&P indicated, Registered nurses completes all pre administration checks. 3. Central lines assessed using strict aseptic techniques. 4. TPN administered via infusion pump only. 5. Monitor lab values blood glucose intake/output, and vital signs. 6 Manage complications per provided orders. 7. Discontinued of TPN is performed by an RN only.Forms: RN TPN Competency Checklist. During a review of the facility's policy and procedure (P&P) titled, Staff Competency Policy and Procedure, dated 11/1/17, the P&P indicated, Purpose . To ensure that all staff at (facility) demonstrate and maintain the knowledge, skills, abilities, and professional behaviors necessary to safely and effectively perform their assigned job duties, in compliance with federal, state, and local regulations, and to promote quality resident care. All staff are competent prior to independently performing assigned duties. Competency: The demonstrated ability to safely and effectively perform assigned job duties . NURSING SERVICES . IV therapy (RN only, if applicable) . TPN management. 2. During a concurrent interview and record review on 1/28/26 at 10:07 a.m. with Director of Staff (continued on next page)

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

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Development (DSD), CNA 1's personnel file (PF) was reviewed. DSD stated CNA 1 did not have the competency evaluation worksheet for onboarding completed. DSD stated CNA 1 did not have the competency evaluation for: hand hygiene, universal precaution (a set of infection control practices that require treating all human blood and certain body fluids for infection), isolation technique (method used to separate a specific component, organism, or variable from a mixed, contaminated, complex environment), and applying and removing Protected Personnel Equipment (PPE- a gear worn to minimize exposure) completed. During a concurrent interview and record review on 1/28/26 at 10:10 a.m. with DSD, CNA 2's PF was reviewed. DSD stated CNA 2 did not have the competency evaluation worksheet for onboarding completed. DSD stated CNA 2 did not have the competency evaluation for: hand hygiene, universal precaution, isolation technique, and applying and removing PPE completed. During a concurrent interview and record review on 1/28/26 at 10:15 a.m. with DSD, CNA 3's PF was reviewed. DSD stated CNA 3 did not have the competency evaluation worksheet for onboarding completed. DSD stated CNA 3 did not have the competency evaluation for: hand hygiene, universal precaution, isolation technique, and applying and removing PPE completed. During a review of the facility's policy and procedure (P&P) titled All Departments - New Employee Orientation, [undated], the P&P indicated, all newly hired employees receive a comprehensive New Employee Orientation prior to assuming independent job responsibilities.No employee may work independently until required orientation components are completed.Director of Staff Development (DSD) .Coordinates and conducts orientation .Maintains orientation and competency records .Maintains employee personnel file.E. Competency and Supervision .Competency validation required prior to independent work. During a review of the facility's P&P titled Job Description, undated, the P&P indicated, Title: Director of Staff Development (DSD).Implement and oversee the facility's in-service training program, ensuring compliance with state and federal training regulations. Provide hands-on training, skill validation, and competency assessment for all nursing staff. 3.During a review of Resident 35's AR, dated 1/19/26, the AR indicated, Resident 35 had a diagnosis of, DEPENDENCE ON RENAL [Kidneys] DIALYSIS.END STAGE RENAL DISEASE [also known as renal failure-the final, irreversible phase of kidney failure where dialysis is required]. During a review of Resident 35's POS, dated 4/30/25, the POS indicated, (Dialysis catheter) Site: Right Femoral [thigh region] MONITOR FOR ANY S/S [sign and symptoms] OF INFECTION AT ACCESS SITE. Right Femoral MONTIOR FOR ANY ITCHING AT ACCESS SITE . During a review of Resident 35's CP, dated 1/20/26, the CP indicated, Potential for complications related to hemodialysis [a life-sustaining treatment for kidney failure that uses a machine and a specialized filter (dialyzer) to remove waste, toxins, and excess fluid from the blood] for diagnosis of Chronic [persistent for long time or constantly recurring illness] Renal Failure. Check shunt [catheter] site for s/s of infection, pain or bleeding daily and PRN [as needed]. During an interview on 1/29/26 at 3:07 p.m. with Treatment Nurse (TN), TN 1 stated, I have not had any training on dialysis catheter care. During an interview on 1/29/26 at 3:11 p.m. with RN 1, RN 1 stated I have not had any training on (continued on next page)

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

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis catheter care. During an interview on 1/29/25 at 4:22 p.m. with DON, DON stated she does not have complete documentation that the staff was trained on dialysis catheter care. During a review of the facility's P&P titled All Departments - New Employee Orientation, [undated], the P&P indicated, Competency and Supervision .Competency validation required prior to independent work. During a review of the facility's P&P titled Job Description, [undated], the P&P indicated, Job Titled: Director of Nursing Services.Evaluate all Registered Nurse in the facility including Supervisory and Charge Nurse and Staff Development.

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

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were stored at proper temperature. This failure had the potential for medication to be ineffective or harmful to residents and staff.Findings:During a concurrent observation and interview on 1/27/26 at 2:01 p.m. with Infection Prevention Nurse (IP) in the facility medication room, three boxes of Prevnar 20-valent Conjugate Vaccine (pneumococcal (flu) vaccine) was stored in the facility freezer temperature at 20 degrees. IP stated the pharmacist stated to store the extra boxes in the freezer. IP stated the box of Prevnar indicated Do not freeze, and the medication should be discarded and not stored in the freezer.During a review of Prevnar's Instructions for Use (IFU) [undated], the IFU's indicated, After shipping, Prevnar 20 may arrive at temperatures between 36 degrees F (Fahrenheit) to 77 degrees F. Upon receipt, store refrigerated at 36 degrees F to 46 degrees F. Do not freeze, Discard if the vaccine has been frozen.During a review of the facility's policy and procedure (P&P) titled , Drug Storage and Labeling undated, the P&P indicated, Policy: Drugs and biologicals will be stored in a safe, secure and orderly fashion, and will be accessible only to licensed nursing or pharmacy personnel. 8. Drugs that are stored at room temperature will be stored in an area no warmer than 86 degrees F. 9. Drugs stored under refrigeration will be stored between 36 degrees F & 46 degrees F.

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

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to provide the correct amount of ingredients to a meal per the facility recipe for three of 22 residents (Resident 21, Resident 51, Resident 80). This failure had the potential for Resident 21, Resident 51, and Resident 80's nutritional and caloric intake to be inaccurate and result in unwanted weight loss or gain. Findings:During a concurrent observation and interview on 1/28/26 at 11:32 a.m. with Facility [NAME] (FC) 1 in the facility kitchen, FC was observed making five quesadillas as a substitute meal for Resident 21, Resident 51, and Resident 80. FC 1 was observed using his hands to grab cheese and dispense unmeasured amounts onto a tortilla. FC 1 stated he had not measured how much cheese was used for the quesadillas and did not know what the facility recipe required as far as amount. During a review of the facility document titled RECIPE: CHEESE QUESADILLA (RCQ), dated 2025, the RCQ indicated, Add 1/2 cup cheese per tortilla.

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

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to:Label and date opened food items. Maintain a clean refrigerator per policy and procedure (P&P) REFRIGERATOR AND FREEZER. Accurately document the temperature of the facility dry food storage area. These failures had the potential to cause food to spoil and cause foodborne illness.Findings:1.During a concurrent observation and interview on 1/26/26 at 8:02 a.m. with Certified Dietary Manager (CDM) in the facility kitchen, the following food items were observed to have no open date or label:One pound (lb.) container of paprika, One lb. container of ground thyme, One lb. container of ground rosemary, One lb. container of sesame seeds, One lb. container of ground cumin, One lb. container of lemon pepper seasoning, One lb. container of dill weed, One lb. container of bay leaves, and Three pink 32-ounce containers with whitish thick liquid substance found in the walk-in refrigerator. There was no indication of what the liquid was.CDM stated per the facility, process food items should have an 'open and used by' date, as well as a label to indicate what the food item is. CDM stated the spice food items observed did not have an open or use by date. CDM stated the three 32-ounce pink pitchers of thick liquid were a drink made for residents, and that should have been labeled to indicate what it was and dated when it was made.During a review of the facility's P&P titled, Dry Storage, [undated], the P&P indicated, Dry food items which have been opened, such as . spices . will be tightly closed, labeled and dated.2. During a concurrent observation and interview on 1/27/26 at 8:40 a.m. with CDM in the facility kitchen, the facility pastry refrigerator was observed. The pastry refrigerator had three levels of shelving that could not be observed due to a buildup of ice of about 1 to 1.5 inches. On the top shelf there was a 7.62 kilogram (kg) box of French fries, on the middle shelf a box of raw cookie dough (weight not specified), and on the bottom shelf a 7.62 kg box of French fires. The very top of the inside of the refrigerator was covered in about 2 inches of ice. CDM stated the facility pastry refrigerator needed to be defrosted (become free of accumulated ice) and cleaned. CDM stated she was not sure when the last time the facility pastry refrigerator was cleaned. During a review of the facility's P&P titled, REFRIGERATOR AND FREEZER, dated 2023, the P&P indicated, Maintaining a clean refrigerator and freezer can improve the safety and quality of your foods. Refrigerator and freezer should be on a weekly cleaning schedule. Remove all items and clean shelves. Wipe with sanitizer. Periodically inspect shelves and replace if coating is chipped away exposing metal shelves.3. During a concurrent interview and record review on 1/28/26 at 10:09 a.m. with Dietary Aide (DA) 1, the facility's DRY STORAGE TEMP (Temperature) LOG (DSTL), dated 1/2026 was reviewed. DA 1 stated she placed the temperature entries for the log on 1/7/26, 1/8/26, 1/9/26, 1/10/26, 1/11/26, 1/13/26, 1/14/26, 1/15/26, 1/16/26, 1/17/26, 1/18/26, 1/20/26, 1/22/26, 1/23/26, 1/25/26, 1/26/26, 1/27/26 and 1/28/26 and that they were all measured at 62 degrees Fahrenheit. DA 1 stated she documented the entries incorrectly as she did not read the thermometer in the dry storage room to get the reading but was looking at the setting of an air conditioner located in the dry storage room. DA 1 was unable to state what the actual temperature of the dry storage room was.During a review of the facility's P&P titled, CORRECTIVE ACTION WHEN FOOD IN THE STORE ROOM REACHES ABOVE 85 (degrees Fahrenheit), dated 2023, the P&P indicated, When temperature within the emergency or food storage room becomes higher than 85 (degrees Fahrenheit), corrective action must take place to ensure food has not become compromised. PROCEDURE . The Dry Food Storage Temperature Log . will be started to monitor storage unit temperatures.

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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interview and record review facility failed to follow its policy and procedure (P&P) titled, Infection Prevention and Control Program, when there was no surveillance conducted on nursing staff. This failure had the potential for unsanitary conditions.Findings:During a concurrent interview and record review on 1/28/26 at 9:27 a.m. with Infection Prevention Nurse (IP), surveillance records (form that audit staff for infection control practices) were reviewed. IP stated there was no surveillance conducted for certified nursing assistants and Licensed and Registered nurses for any infection control practices. IP stated it should have been done. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 12/1/2021, the P&P indicated, V. Gathering Surveillance Data.E. At least on a monthly basis, the IP. will conduct an infection control audit.

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 01/29/2026
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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 23 of 34 resident rooms measured at least 80 square feet per resident. This failure had the potential for residents to experience negative outcomes due to having insufficient personal space in their rooms.Findings:During a review of facility documented titled Client Accommodation Analysis (CAA), (a facility document indicating the size of resident rooms), [undated], the CAA indicated the following room measurements:room [ROOM NUMBER]: 153 square feetroom [ROOM NUMBER]: 154 square feetroom [ROOM NUMBER]: 132 square feetroom [ROOM NUMBER]: 210 square feetroom [ROOM NUMBER]: 210 square feetroom [ROOM NUMBER]: 210 square feetroom [ROOM NUMBER]: 225 square feetroom [ROOM NUMBER]: 210 square feetroom [ROOM NUMBER]: 156 square feetroom [ROOM NUMBER]: 220 square feetroom [ROOM NUMBER]: 220 square feetroom [ROOM NUMBER]: 220 square feetroom [ROOM NUMBER]: 220 square feetroom [ROOM NUMBER]: 220 square feetroom [ROOM NUMBER]: 220 square feetroom [ROOM NUMBER]: 220 square feetroom [ROOM NUMBER]: 220 square feetroom [ROOM NUMBER]: 220 square feetroom [ROOM NUMBER]: 220 square feet room [ROOM NUMBER]: 220 square feetroom [ROOM NUMBER]: 220 square feetroom [ROOM NUMBER]: 220 square feetroom [ROOM NUMBER]: 220 square feetDuring a review of the Resident List Report (RLR) (a document indicating the number of residents in the facility and their respective rooms), dated 1/25/26, the RLR indicated the following number of residents in each room:room [ROOM NUMBER]: two beds (resulting in 76.5 square feet of space per resident)room [ROOM NUMBER]: two beds (resulting in 77 square feet of space per resident) room [ROOM NUMBER]: two beds (resulting in 66 square feet of space per resident) room [ROOM NUMBER]: three beds (resulting in 70 square feet of space per resident)room [ROOM NUMBER]: three beds (resulting in 70 square feet of space per resident)room [ROOM NUMBER]: three beds (resulting in 70 square feet of space per resident)room [ROOM NUMBER]: three beds (resulting in square feet of space per resident)room [ROOM NUMBER]: three beds (resulting in 70 square feet of space per resident)room [ROOM NUMBER]: two beds (resulting in 75 square feet of space per resident)room [ROOM NUMBER]: three beds (resulting in 73 square feet of space per resident)room [ROOM NUMBER]: three beds (resulting in 73 square feet of space per resident)room [ROOM NUMBER]: three beds (resulting in 73 square feet of space per resident)room [ROOM NUMBER]: three beds (resulting in 73 square feet of space per resident)room [ROOM NUMBER]: three beds (resulting in 73 square feet of space per resident)room [ROOM NUMBER]: three beds (resulting in 73 square feet of space per resident)room [ROOM NUMBER]: three beds (resulting in 73 square feet of space per resident)room [ROOM NUMBER]: three beds (resulting in 73 square feet of space per resident)room [ROOM NUMBER]: three beds (resulting in 73 square feet of space per resident)room [ROOM NUMBER]: three beds (resulting in 73 square feet of space per resident) room [ROOM NUMBER]: three beds (resulting in 73 square feet of space per resident)room [ROOM NUMBER]: three beds (resulting in 73 square feet of space per resident)room [ROOM NUMBER]: three beds (resulting in 73 square feet of space per resident)room [ROOM NUMBER]: three beds (resulting in 73 square feet of space per resident)During an interview on 1/29/26 at 9:41 a.m., with the Administrator, the Administrator stated the above rooms did not measure at least 80 square feet per resident.During the survey, no residents in the above rooms identified with providing fewer than 80 square feet per resident were negatively affected by the size of their rooms.During a review of the facility's policy and procedure (P&P) titled, Maintenance Services, dated 11/1/17, the P&P indicated, The Maintenance Department is responsible for . Maintaining the building in compliance with current federal, state, and local laws, regulations and guidelines.