STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555479	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delano District Skilled Nursing Facility	1509 Tokay Street Delano, CA 93215

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 37697 Based on interview and record review, the facility failed to treat four of seven sampled residents (Resident 1, Resident 2, Resident 3, and Resident 7) with dignity and respect. This failure had the potential for negative consequences up to and including psychological harm. Findings: During a review of Resident 2 ' s Minimum Data Set (MDS - an assessment tool) under Brief Interview for Mental Status (BIMS - an assessment tool for cognition), dated 12/11/23, the BIMS indicated, Resident 2 had a score of 15 out of 15 (cognition is intact). During an interview on 12/11/23 at 1:30 p.m. with Resident 2, Resident 2 stated approximately three Sundays ago he had a concern for his friend Resident 1 ' s health. Resident 2 stated Resident 1 was having multiple uncontrolled seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness). Resident 2 stated he told Registered Nurse (RN) 1 about Resident 1 not looking good and she (RN 1) told him, Get out of here, you are not supposed to be here. Resident 2 stated RN 1 then left the room and did not check Resident 1. Resident 2 stated Resident 1 was eventually sent out to the hospital on 11/19/23 by other nurses and was gone for a week. Resident 2 stated since Resident 1 returned he had been in, bad shape. Resident 2 stated he spoke with Administrator regarding the incident and Administrator stated he would conduct an investigation, since there had been other complaints from different residents about RN 1. During a review of Resident 1 ' s MDS under section BIMS dated 11/29/23, the BIMS indicated, Resident 1 had a score of 15 out of 15. During an interview on 12/11/23 at 1:34 p.m. with Resident 1, Resident 1 stated he was sent to the hospital a few weeks ago on 11/19/23 due to having multiple seizures. Resident 1 stated he was at the hospital for approximately five days. Resident 1 stated Resident 2 was very concerned when he was having multiple seizures and was upset at RN 1. Resident 1 stated Resident 2 was correct to be worried as he was worried too. During a review of Resident 3 ' s MDS under section BIMS dated 10/10/23, the BIMS indicated, Resident 3 had a score of 15 out of 15. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/11/23 at 2:12 p.m. with Resident 3, Resident 3 stated RN 1 had a bad attitude. Resident 3 stated, She [RN 1] has a strange attitude in which she [RN 1] comes off as not caring. When I [Resident 3] was here [in the facility] in the beginning she [RN 1] had a bad attitude with me. She [RN 1] would talk to me rudely. During an interview on 12/11/23 at 3:14 p.m. with Administrator, Administrator stated RN 1 was recently written up for being rude to a hospice [end of life care] residents [unidentified] family. Administrator stated Resident 2 had approached him about an incident with RN 1 and there was an investigation being done. During an interview on 12/13/23 at 10:07 a.m. with RN 1, RN 1 stated the day Resident 1 was having multiple seizures she felt that he (Resident 1) was just pretending. RN stated, Yeah, I told him [Resident 2] to leave. I told him [Resident 2] go to your room and let me do my job. During an interview on 12/18/23 at 11:40 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was present during the altercation with Resident 2 and RN 1 when Resident 1 was having seizures. LVN 2 stated RN 1 told Resident 2 to get away and he did not belong there. LVN 2 stated RN 1 told her and the other staff in front of Resident 2, He [Resident 2] was being nosey. During a review of Resident 7 ' s MDS under section BIMS dated 1/15/24, the BIMS indicated, Resident 7 had a score of 15 out of 15. During an interview on 1/17/24 at 9:41 a.m. with Resident 7, Resident 7 stated when she met RN 1, she was intimidated by her. Resident 7 stated RN 1 can come off as very intimidating. During an interview on 1/17/24 at 10:06 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated RN 1 was in general very rude and mean to staff and residents. During an interview on 1/17/24 at 10:45 a.m. with CNA 2, CNA 2 stated Resident 2 was very upset during the altercation with RN 1 and had called Resident 1 ' s family to tell them how she had acted. During a review of RN 1 ' s Employee File (EF), the EF indicated the following: A. On 11/11/23 - RN 1 was written up by the facility for not responding in a timely manner to a family ' s request for a nurse during a change of condition (a sudden clinically important deviation in a resident ' s baseline). RN 1 was found at the nurses ' station on her personal phone and made discourteous remarks to the family such as, You need to calm down. You ' re freaking out. He ' s [unidentified resident] on hospice [end of life care] without empathy. B. On 10/15/23 - Facility Social Services Director placed a memo that RN 1 had numerous complaints from residents about her attitude. Resident 7 was listed as one of the residents who had made a complaint. C. On 4/8/23 - RN 1 had an incident with a daughter of an unidentified resident in which RN 1 was rude to her and did not speak with the daughter in a private area when discussing concerns. D. On 12/10/22 - RN 1 failed to stay on shift until properly relieved for residents to be covered (abandonment). (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A request for policy and procedure on dignity and respect was made to the DON on 1/17/24 at 10:58 a.m. but none was provided.

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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** 37697 Based on observation, interview, and record review, the facility failed to provide the necessary care and services for one of seven sampled residents (Resident 1) when Resident 1 experienced repeated seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness) and the Registered Nurse (RN 1) failed to identify the seizure activity, call the physician promptly, send Resident 1 out to a higher level of care promptly and ensure qualified staff monitored the resident when the resident was experiencing seizures. These failures resulted in a delay in receiving prompt medical attention and resulted in an overall decline in Resident 1 ' s physical condition. Findings: During a review of Resident 1 ' s Admission Record (AR) dated [DATE], the AR indicated, diagnoses including Unspecified convulsions (sudden, violent, irregular movement of a limb or of the body, caused by involuntary contraction of muscles and associated especially with brain disorders), Muscle weakness, Chronic Obstructive Pulmonary Disease (disease that damages your lungs over time). During a review of Resident 1 ' s MDS (Minimum Data Set - an assessment tool) under Brief Interview for Mental Status (BIMS - an assessment tool for cognition [the mental processes that take place in the brain]) dated [DATE], the BIMS indicated, Resident 1 had a score of 15 out of 15 (intact cognition). During a concurrent observation and interview on [DATE] at 1:34 p.m. with Resident 1 outside the resident dining area, Resident 1 was tearful and had oxygen being delivered via nasal cannula (tube into your nose to deliver oxygen). Resident 1 stated he was sent to the acute hospital a few weeks ago ([DATE]) due to having multiple seizures. Resident 1 stated he was at the hospital for approximately five days. Resident 1 stated after returning from the acute hospital, he now required continuous oxygen and has had difficulty with swallowing. Resident 1 stated he was going to have a swallow evaluation to determine if he was at risk for choking. Resident 1 stated when he eats, he feels as if food is getting stuck in his throat. Resident 1 stated he was tearful due to all the medical issues he has had over the last few weeks. During an interview on [DATE] at 10:07 a.m. with RN 1, RN 1 stated on [DATE] she felt the resident was pretending to have seizures. During an interview on [DATE] at 11:13 a.m. with Director of Nursing (DON), DON stated Licensed Vocational Nurse (LVN 1) contacted her on [DATE] to obtain permission to send Resident 1 out to the acute hospital due to the resident having multiple seizures and RN 1 refusing to send him out to the hospital. DON stated she spoke with RN 1 as to the reason RN 1 would not send Resident 1 out on [DATE] and RN 1 stated she did not feel the resident was truly having seizures. DON stated since Resident 1 ' s return from the acute hospital his condition has changed. Resident 1 now required continuous oxygen and he was having difficulty with swallowing. He required a swallowing evaluation due to concerns with him choking when he eats. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 10:51 a.m. with LVN 1, LVN 1 stated she knew Resident 1 was having seizures on [DATE] as Resident 1 would become non-responsive and his upper body would shake. LVN 1 stated she timed the seizures, and each seizure was lasting seven to nine minutes each. LVN 1 stated Resident 1 had approximately six seizures in the facility hallway. LVN 1 stated LVN 2 gave Resident 1 his seizure medication (Valtoco - a prescription nasal spray rescue medication used for the short-term treatment of seizure clusters) at around 9:13 a.m. but it was ineffective. LVN 1 stated she and LVN 2 called RN 1 about Resident 1 ' s continuous seizures and to request RN 1 to send Resident 1 out to the acute hospital for higher level of care. LVN 1 stated RN 1 had staff place Resident 1 in his room and ordered all staff except for Certified Nursing Assistant (CNA) students to leave. LVN 1 stated Resident 1 continued to have multiple seizures while in his room. LVN 1 stated RN 1 then left Resident 1 in his room with CNA students and then went to other resident rooms searching for a hairdryer to dry her cell phone. LVN 1 stated RN 1 had spilled coffee on her cell phone. LVN 1 stated RN 1 was more concerned about her cell phone being wet and looking for a hairdryer than Resident 1 ' s medical condition. LVN 1 stated LVN 2 approached RN 1 and tried to convince her to send Resident 1 out to the acute hospital for higher level of care, but RN 1 screamed at LVN 2 and stated she would not send Resident 1 out. During an interview on [DATE] at 11:40 a.m. with LVN 2, LVN 2 stated she was assigned to Resident 1 on [DATE]. LVN 2 stated at approximately 9 a.m. Resident 1 began having seizures in the facility hallway. LVN 2 stated she and LVN 1 timed Resident 1 ' s seizures and seizures lasted approximately up to 10 minutes each. LVN 2 stated Resident 1 ' s seizures would present as him not being responsive, his eyes rolling in the back of his head and his whole body shaking. LVN 2 stated she contacted RN 1 about Resident 1 ' s continuous seizures. LVN 2 stated RN 1 instructed her to give Resident 1 his Valtoco. LVN 2 stated she informed RN 1 there was no more Valtoco medication available for Resident 1 after she gave the initial dose. RN 1 instructed the CNA students to monitor the resident in his room. RN 1 then began looking around the resident rooms and asking other residents for a hairdryer because RN 1 spilled coffee on her cell phone. LVN 2 stated RN 1 was more concerned about her cell phone and finding a hair dryer than Resident 1 ' s medical condition. LVN 2 stated she and LVN 1 attempted four times from 9 a.m. to 10:30 a.m. to get RN 1 to send Resident 1 to the acute hospital due to multiple seizures but RN 1 stated, Shut the [explicit] up you ' re stressing me out. LVN 2 stated Resident 1 had about five more seizures after being given the Valtoco. LVN 2 stated she called DON due to RN 1 ' s refusal to send Resident 1 to the acute hospital so she could be instructed on how to send Resident 1 on her own without RN 1. LVN 2 stated Resident 1 had approximately eight seizures one after the other in total before being sent out to the hospital by ambulance on [DATE] at approximately 12:40 p.m. During a review of Resident 1 ' s Order Summary (OS), dated [DATE], the OS indicated, Resident 1 doctor ordered Valtoco 15 milligrams (mg - a unit of measurement) to be given via nasal (nostril) route. One spray of the medication in the nostril every 10 minutes as needed for breakthrough seizures for two uses. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 10:06 a.m. with CNA 1, CNA 1 stated she was assigned to Resident 1 on [DATE]. CNA 1 stated Resident 1 was up in a chair in the hallway when he had his first seizure approximately after 9 a.m. CNA 1 stated Resident 1 ' s first seizure that day was noticed because his head tilted back, he was not alert and his left hand shook continuously. CNA 1 stated LVN 2 gave Resident 1 his Valtoco. CNA 1 stated the medication was only effective for about three minutes before Resident 1 began to have more seizures. CNA 1 stated RN 1 instructed the CNA students to monitor Resident 1 and no one else to be with him. CNA 1 stated the CNA students and their instructor stated they were not appropriate to monitor Resident 1 in his current condition. CNA 1 stated despite the verbalized concerns, RN 1 only allowed the CNA students to monitor Resident 1. CNA 1 stated Resident 1 ' s lips would turn purple, and he would cough continuously during his seizures. CNA 1 stated, It was not fair for [Resident 1] to be left like that. He had approximately seven seizures before being sent out [to the acute hospital]. We [facility staff] were worried about him and wondering why he was not being sent out. [RN 1] was saying he was just being anxious. During an interview on [DATE] at 10:58 a.m. with DON, DON stated her expectation for a resident who was experiencing continuous seizures and not responsive to medication, is for the nurse to complete a full assessment, to notify the doctor and send the resident out to the acute care for higher level of care need. DON stated, I would not leave a [CNA] student to monitor the resident [Resident 1] as they do not have the appropriate training nor knowledge. During a review of Resident 1 ' s clinical record, Licensed Vocational Nurse (LVN 2) Progress Notes (PN) dated [DATE] at 3:10 p.m. were reviewed. The PN indicated, Resident [1] began having seizures [at 9 a.m.] in the hallway during medication pass. Resident [1] was in the hallway with CNA [Certified Nursing Assistant - CNA 1] present. Seizures continued happening back-to-back less than 30minutes [sic] apart lasting , d+[DATE] minutes at a time. Notified RN supervisor [RN 1] advised to give [seizure medication] nasal spray, informed RN [1] supervisor last dose was given . Medication ineffective. RN [1] had students and CNA [not identified] put resident [1] back to bed, and asked students to monitor resident. CNA ' s [not identified] and staff [not identified] urged RN [1] to let CNA [not identified] be at bedside while students took over section [due to] students not being comfortable initiating CPR [cardiopulmonary resuscitation - an emergency procedure to help sustain life] if needed. RN [1] stated was not necessary . Resident [1] continued having seizures RN [1] refused to send resident [1] out to ER [emergency room]. Contacted [Director of staff Development] to obtain ok to send out resident [to the emergency room] . Ambulance arrived and given report by myselfambulance [sic] [LVN 2] stated ' why was resident [1] not sent out sooner he could have lost oxygen to his brain having so many seizures like that back to back, you will be lucky if state doesn ' t get down on you for this ' . During a review of Resident 1 ' s Ambulance Service Report (ASR) dated [DATE] (time of report not indicated), the ASR indicated an ambulance arrived for Resident 1 at approximately 12:18 p.m. The ASR indicated, 70year old male, chief complaint . seizures . [Resident 1] seizures are lasting approximately 10 minutes each about 20 minutes apart. His [Resident 1] las [sic] seizure began at [12:38 p.m.] and [Resident 1] did not come out of this seizure while under [ambulance staff - unidentified] care. [Resident 1] was transported to the nearest hospital due to status. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s acute hospital Discharge Summary (DS), dated [DATE], the DS indicated Resident 1 was sent from the local acute hospital emergency room to another acute hospital 31 miles away for higher level of care in which a neurologist (a physician that deals with managing disorders of the brain and nervous system) was required. The DS indicated Resident 1 was admitted on [DATE] and discharged [DATE]. The DS indicated, Discharge Diagnosis . recurrent breakthrough seizures . status epilepticus (a medical emergency when there is a continuous seizure lasting more than 30 min, or two or more seizures without full recovery of consciousness between any of them) . Acute encephalopathy (a change on how the brain functions) . patient [Resident 1] had multiple episodes of seizure in the hospital as well. EEG [electroencephalogram - an assessment device that records brain activity] showing 2 spike-wave discharges [abnormal result consistent with showing epilepsy in a patient] consistent with seizure focus [the site in the brain from which a seizure originates] . Please note that this is a prolonged hospitalization . During a review of Resident 1 ' s MDS under Section GG - Functional Abilities and Goals (GGF - an assessment tool used to evaluate a residents ' functional capabilities) dated [DATE] (prior to Resident 1 ' s [DATE] hospitalization), the GGF indicated the following: a. Resident 1 was independent with oral hygiene. b. Resident 1 was independent with his toilet hygiene. c. Resident 1 was set up assistance to shower/bathe self. d. Resident 1 was independent with upper and lower body dressing. e. Resident 1 was independent with putting on/taking off his footwear. f. Resident 1 was independent with his personal hygiene. g. Resident 1 was independent with movement that required rolling left and right. h. Resident 1 was independent with sitting to lying. i. Resident 1 was independent with sitting on the side of the bed. j. Resident 1 was independent with sitting to standing. k. Resident 1 was independent with chair/bed transfer. l. Resident 1 was independent with toilet transfer. m. Resident 1 was independent with tub/shower transfer. n. Resident 1 was independent in walking 10 feet (a unit of measurement), 50 feet with two turns and walking 150 feet. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s MDS under section GGF dated [DATE] (after his return from hospital on [DATE]), the GGF indicated Resident 1 had a change of condition from the previous GGF done on [DATE] in which: a. Resident 1 required set up or clean up assistance with oral hygiene. b. Resident 1 was dependent on staff for toilet hygiene. c. Resident 1 was dependent on staff to shower/bathe self. d. Resident 1 was dependent on staff for upper and lower body dressing. e. Resident 1 was dependent on staff for putting on/taking off his footwear. f. Resident 1 was dependent on staff for personal hygiene. g. Resident 1 required maximal assistance from staff to roll left and right. h. Resident 1 required maximal assistance from staff with sitting to lying. i. Resident 1 required maximal assistance from staff with sitting on the side of the bed. j. Resident 1 required maximal assistance from staff for sitting to standing. k. Resident 1 required maximal assistance from staff for chair/bed transfer. l. Resident 1 required maximal assistance from staff for toilet transfers. m. Resident 1 required supervision or touching assistance from staff for tub/shower transfer. n. Resident 1 required moderate assistance to walk 10 feet and was not able to walk 50 feet or 150 feet due to safety concerns. During a review of Resident 1 ' s OSR, dated [DATE] (prior to [DATE] hospitalization), the OSR indicated, Resident 1 had a doctor ' s order placed on [DATE] for oxygen two liters (a unit of measurement) as needed for shortness of breath. During a review of Resident 1 ' s OSR, dated [DATE] (after [DATE] hospitalization), the OSR indicated, Resident 1 was to have oxygen two liters continuously every shift. During a review of Resident 1's Order Summary Report (OSR), dated [DATE] (prior to [DATE] hospitalization), the OSR indicated, Resident 1 had a diet order consisting of no added salt regular texture food with thin liquids. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Speech Therapy SLP (speech language pathologist) Evaluation and Plan of Care (SLPEC), dated [DATE], the SLPEC indicated Resident 1 diagnosis of epilepsy and dysphagia (difficulty swallowing). The SPLEC indicated Resident 1 is on a new puree (food that does not need to be chewed) diet. The SLPEC indicated, Reason for referral: [Resident 1] referred to [speech therapy] due to new onset of risk for aspiration [choking] and signs/symptoms of dysphagia . Clinical impression: [Resident 1] presents with [signs and symptoms] of esophageal [portion of body that connects from mouth to stomach] dysphagia with food getting stuck in the area of the UES [upper esophageal sphincter - area of the stomach where there is a passage that prevents stomach contents from going up]. During a review of the facility ' s job description (JD) titled, Charge Nurse/Supervisor, not dated, the JD indicated, The primary purpose of your job position is to provide direct care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, regulations that govern our facility, and as may be required by the Director of Nursing Services or Nurse Supervisor to ensure that the highest degree of quality care is maintained at all times .Duties and Responsibilities . Admit, transfer, and discharge residents as required . Provide direct nursing care . Monitor seriously ill residents as necessary. During a review of the facility ' s policy and procedure (P&P) titled, Change of Condition, dated [DATE], the P&P indicated, PURPOSE: To keep residents, family and physicians informed in a timely manner . Notify the attending physician promptly . when there is . A change in the resident ' s physical, mental or psychosocial status, (i.e. [id est - latin for that is] deterioration in physical, mental, or psychosocial status, life threatening condition or clinical complications .) . PHYSICIAN NOTIFICATION . In emergency/life threatening situations . RN Supervisor or charge nurse will assess the resident and immediately call the attending physician . For situations where the physician cannot be reached right away . call the ambulance of the emergency or 911 .