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	06/20/2024

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

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. 37697 Based on interview and record review the facility failed to implement their policy and procedure (P&P) on abuse for one of three residents (Resident 1) when: a. Certified Nursing Assistant (CNA) 1 did not immediately report an allegation of abuse to facility management. b. CNA 1 was not removed from working with residents immediately after an allegation of abuse. These failures resulted in a potential delay in investigation, had the potential for abuse to continue and had the potential for other residents to be abused. Findings: During a review of Resident 1's Minimum Data Set (MDS- an assessment tool) under the section BIMS (Brief Interview for Mental Status - an assessment of cognition [mental processes including perception, memory, and thought], dated 3/1/24, the BIMS indicated, Resident 1 had a score of 14 (Cognitively intact). During an interview on 6/20/24 at 11:27 a.m. with Resident 1, Resident 1 stated he had an altercation with CNA 1, in which CNA 1 allegedly punched him. Resident 1 could not recall the date the alleged abuse occurred. During an interview on 6/20/24 at 12:10 p.m. with Social Services Director (SSD), SSD stated on 6/15/24 Resident 1 had made an allegation of abuse toward CNA 1. During an interview on 6/20/24 at 12:30 p.m. with Director of Nursing (DON), DON stated Family Member (FM) 1 was told by Resident 1 that he was abused by CNA 1. DON stated FM 1 did not tell staff about the allegation of abuse because FM 1 knows Resident 1 can be difficult and make things up. DON stated the allegation of abuse Resident 1 made was on 6/15/24. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(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	During an interview on 6/20/24 at 12:46 p.m. with CNA 1, CNA 1 stated he had assisted Resident 1 with going to the restroom on 6/14/24. CNA 1 stated during the time he was providing assistance Resident 1 became agitated and was yelling at him in Spanish. CNA 1 stated later that day (6/14/24) FM 1 had approached him at approximately 8 p.m. and accused him of abusing Resident 1 and bruising his arms. CNA 1 stated he did not report the allegation of abuse to anyone, and he had continued to finish the remainder of his shift until he went home at approximately 10:30 p.m. CNA 1 stated, I [CNA 1] felt like [FM 1] was accusing me of giving bruises all over [Resident 1's] hands and abusing him. CNA 1 stated it was his mistake that he did not report the allegation of abuse. During a review of the facility PrintTimecardDialog (PTD- employee timecard of hours worked), dated 6/1/24 to 6/15/24, the PTD indicated CNA 1 worked on 6/14/24 from 1:53 p.m. to 10:30 p.m. During an interview on 6/20/24 at 1:15 p.m. with Administrator, Administrator stated CNA 1 required more training on the facility abuse reporting process. During an interview on 6/24/24 at 10:47 a.m. with FM 1, FM 1 stated, on 6/14/24 she had received a call from Resident 1 that he had been abused by CNA 1. FM 1 stated she went to the facility and Resident 1 again stated he had been abused by CNA 1. FM 1 stated at approximately 7 p.m. she had went to CNA 1 and told him about the allegation of abuse. FM 1 stated she also asked other CNAs (not identified) around the facility about what had happened (between CNA 1 and Resident 1) and they had all stated they were not around to know what occured. FM 1 stated the following day 6/15/24 she receieved a call from the facility that an investigation would need to take place and the police department would be called regarding Resident 1's allegation of abuse. During a review of the facility's policy and procedure (P&P) titled, ABUSE PREVENTION PROGRAM, dated 7/22/21, the P&P indicated, It is encouraged that employees, facility consultants, attending physicians, family members, visitors, and volunteers promptly report any incident or suspected incident of neglect or resident abuse, including injuries of an unknown source, to facility management. When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source, or physical abuse is reported, the Nursing Supervisor or Supervisor of the mandated reporter, shall notify the appropriate person and agencies as listed below .The Resident's Responsible Party . The Resident's attending physician .The Ombudsman or Local Law Enforcement; and .CDPH (regardless of resident to resident abuse, in which the perpetrator has a diagnosis of Dementia, and such abuse resulted in no serious bodily injury). All employees and persons working in a Long-Term Care facility are mandated by California Law to report incidents of resident abuse or suspected incidents of abuse. During abuse investigations, residents will be protected from harm by the following measures . Employees accused of participating in the alleged abuse shall be placed on administrative leave until the Administrator, SSD and/or DON has reviewed the results of the investigation. All reports of resident abuse, neglect and injuries of an unknown source shall be promptly and thoroughly investigated by facility management.