

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Delano District Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37697</p> <p>Based on observation, interview, and record review, the facility failed to report allegations of abuse to the state agency for five of eight sampled Residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5) when:</p> <p>A. Resident 1 reported to staff multiple incidents of physical altercation with Resident 2.</p> <p>B. Resident 3 reported to staff multiple incidents of sexual allegations against Resident 4.</p> <p>C. Staff witnessed Resident 4 being sexually inappropriate with Resident 5.</p> <p>These failures had the potential for delayed investigation and put all residents at risk for further abuse.</p> <p>Findings:</p> <p>A. During an interview on 9/12/24 at 2:51 p.m. with Social Services Assistant (SSA), SSA stated on 8/19/24, Resident 1 informed the staff he had a physical altercation with Resident 2. SSA stated her and Social Services Director (SSD) checked the facility security cameras and found no evidence Resident 1 and Resident 2 had a physical altercation. SSA stated the allegation of physical abuse between Resident 1 and Resident 2 was not reported to the California Department of Public Health (CDPH) because SSD stated they could not find evidence the physical altercation occurred. SSA stated the allegation should have been reported, Any allegation is reportable to CDPH whether true or false.</p> <p>During a review of Resident 2 ' s Progress Notes (PN), dated 8/19/24, the PN indicated, (Social Services) Staff investigated accusations between two residents (Resident 1 and Resident 2) about alleged physical altercation between them, immediate investigation proved that it is unfounded for abuse or suspected abuse.</p> <p>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 8/12/24, the BIMS indicated, Resident 1 had a score of 13 (cognitively intact).</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/16/24 at 12:15 p.m. with Resident 1, Resident 1 stated, (Resident 2) is crazy. Every time (Resident 2) see me, he wants to hit me. Resident 1 stated the last encounter (could not recall date) he had with Resident 2, Resident 2 tried to hit him, and Resident 1 had placed his hand on Resident 2 ' s chest to keep him away. Resident 1 stated Resident 2 fell to the floor when he (Resident 1) placed his hand on Resident 2 ' s chest to prevent him from striking him. Resident 1 stated he talked to SSD about his issues with Resident 2 and SSD told him if the incidents continued, one of them would have to leave the facility. Resident 1 stated he spoke with both SSA and SSD approximately one month ago about Resident 2 ' s attempt to strike him and the fall incident.</p> <p>During an interview on 9/16/24 at 12:33 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 2 was fixated on Resident 1. CNA 1 stated the facility staff must keep Resident 1 and Resident 2 separated and redirect them away from each other.</p> <p>During an interview on 9/18/24 at 11:13 p.m. with Activities Assistant (AA), AA stated she was aware Resident 1 and Resident 2 had multiple altercations but was not sure of specific times or dates. AA stated approximately one month ago, Resident 2 had to be redirected away from Resident 1 during church due to Resident 2 verbalizing wanting to hit Resident 1. AA stated Resident 1 pushed Resident 2 causing a fall or Resident 2 fell on the floor after an altercation with Resident 1. AA stated approximately two and a half weeks ago Resident 1 was sitting by a window in which she observed Resident 2 heading towards Resident 1 to strike him. AA stated she intervened and redirected Resident 2 before he was able to strike Resident 1. AA stated she reported this incident to SSA.</p> <p>During an interview on 9/18/24 at 11:39 a.m. with Director of Nursing (DON), DON stated she spoke to Resident 2 ' s CNA (not identified) after his fall incident approximately one month ago and had noted Resident 2 later that evening was trying to strike Resident 1 with a spoon.</p> <p>During a review of Resident 1 and Resident 2 ' s Electronic Medical Record (EMR), dated 1/2024 to 9/2024, the EMR indicated, no documentation of physical altercations noted between Resident 1 and Resident 2.</p> <p>B. During an interview on 9/12/24 at 2:51 p.m. with SSA, SSA stated SSD received a report from Resident 3 (female) about Resident 4 (male) going into her room uninvited. SSA stated her and SSD checked the facility cameras and did not see any evidence of Resident 4 entering Resident 3 ' s room.</p> <p>During a review of Resident 4 ' s Progress Notes (PN), dated 8/20/24, the PN indicated, Resident 4 was referred to psychology by social services for wandering into female resident rooms and verbalizing sexual remarks. On 8/6/24 the PN indicated Resident 4 was on monitoring for sexual remarks to another resident (not indicated who).</p> <p>During a review of Resident 3 ' s MDS under the section BIMS, dated 9/3/24, the BIMS indicated, Resident 3 had a score of 15 (cognitively intact).</p> <p>During a review of Resident 4 ' s MDS under the section BIMS, dated 7/5/24, the BIMS indicated, Resident 4 had a score of 6 (severe cognitive impairment).</p> <p>During a review of Resident 4 ' s ADMISSION RECORD (AR), dated 9/16/24, the AR indicated, Resident 4 had a diagnosis of Alzheimer ' s Disease (a disease characterized by a progressive decline in mental abilities) and dementia (a progressive state of decline in mental abilities).</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/16/24 at 10:05 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was assigned to Resident 4. LVN 1 stated when she worked where Resident 3 was located, she heard Resident 4 had come over to that side and touched another resident (was not sure what resident).</p> <p>During an observation on 9/16/24 at 10:36 a.m. in the facility patio, Resident 4 was observed propelling his wheelchair without difficulty.</p> <p>During an interview on 9/16/24 at 11:39 a.m. with Resident 3, Resident 3 stated she had three encounters with Resident 4 in which he was sexually inappropriate. Resident 3 stated the first time was in the facility patio about a month ago. Resident 3 stated Resident 4 approached her and stated he missed sex as he grabbed his crotch. Resident 3 stated Resident 4 asked her if he could go with her to her room or if they could go back to his room. Resident 3 stated she told Resident 4 to leave. Resident 3 stated she came back into the facility after the incident and was crying in which CNA 2 noticed and asked what was wrong. Resident 3 stated CNA 2 encouraged her to report what happened to the Social Services Department. Resident 3 stated she reported the incident to the Social Services Department. Resident 3 stated the second incident happened a few days after the first incident (no specific date). Resident 3 stated she was lying in bed when Resident 4 came into her room through a closed door and approached her bed. Resident 3 stated Resident 4 had asked if she wanted to, Fool around. Resident 3 stated she pretended sleeping and Resident 4 stated she knew where his room was and left. Resident 3 stated she reported this incident to SSA and SSD. Resident 3 stated the third encounter she had with Resident 4 (no specific date) was in her area of the facility in which she had to tell him she was going to call the police and staff (not sure who) redirected him out of her area. Resident 3 stated she does not like to go to the patio area anymore and she looks around her area because she feels bothered and in shock when she encounters Resident 4. Resident 3 stated, See you report it (incidents with Resident 4), and they (social services/facility) don ' t do anything. I ' ve gone over there (Social Service Department), and they (SSA, SSD) don ' t do anything. It seems like these girls (SSA, SSD) are not doing their job.</p> <p>During a review of Resident 3 ' s Electronic Medical Record (EMR), dated 1/2024 to 9/2024, the EMR indicated, no documentation of incidents nor reports regarding the three sexual allegations with Resident 4 she spoke to SSA and SSD about.</p> <p>During an interview on 9/16/24 at 12:05 p.m. with CNA 3, CNA 3 stated Resident 3 is a quiet resident who preferred to stay to herself and in her room. CNA 3 stated she was aware of Resident 3 ' s allegations about Resident 4 making unwanted sexual remarks toward her but cannot remember when the incident occurred. CNA 3 stated all the facility staff know to redirect Resident 4 out of Resident 3 ' s area. CNA 3 stated the facility staff were not given an in-service to redirect Resident 4, it was just something everyone knew to do because Resident 3 was crying after the incident with Resident 4.</p> <p>During an interview on 9/16/24 at 12:12 p.m. with LVN 2. LVN 2 stated, (Resident 4) is to be redirected out of the same area of the facility (Resident 3) is in. LVN 2 stated the Director of Nursing (DON) and Director of Staff Development (DSD) told staff to keep Resident 4 out of the area of the facility where Resident 3 was located due to some type of incident (was not told specific reason). LVN 2 stated this was told to staff about two or three months ago.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/16/24 at 1:22 p.m. with DON, DON stated she was aware Resident 3 does not like Resident 4 but was not sure of the reason. DON stated she did hear SSD looking into Resident 3 making a sexual allegation, but nothing was found. DON stated if there was an allegation Resident 4 entered Resident 3 ' s room and asked for sexual favors it needed to be reported to the state agency.</p> <p>During an interview on 9/18/24 at 10:53 a.m. with CNA 2, CNA 2 stated he recalled Resident 3 coming in from the patio crying and appearing in shock about one to three months ago. CNA 2 stated Resident 3 requested to speak to the Social Services Department but was never told the reason. CNA 2 stated shortly after Resident 3 spoke with Social Services, the facility staff were instructed by the DSD to make sure Resident 4 was redirected away from Resident 3.</p> <p>During an interview on 9/18/24 at 11:28 a.m. with DSD, DSD stated she could not recall telling any staff about redirecting Resident 4 out of Resident 3 ' s area. DSD stated she was aware Resident 4 was to be redirected away from Resident 3 ' s area but was not sure of the reason.</p> <p>During an interview on 9/18/24 at 12:32 p.m. with SSA, SSA stated on 8/5/24 Resident 3 submitted a grievance to SSD indicating on 8/3/24 Resident 4 entered her room and was being sexually inappropriate. SSA stated the allegation made was and should have been reported to CDPH.</p> <p>C. During an interview on 9/16/24 at 12:33 p.m. with CNA 1, CNA 1 stated she received a report three or four months ago from Physical Therapy Assistant (PTA) about Resident 4 (male) grabbing Resident 5 ' s (female) hand and placed it on his crotch area. CNA 1 stated she reported the incident to her supervisors but could not remember who she told.</p> <p>During an interview on 9/16/24 at 12:59 a.m. with PTA, PTA stated approximately three or four months ago he observed Resident 4 grabbing Resident 5 ' s hand and placing it on his crotch. PTA stated it appeared Resident 5 had her hand in Resident 4 ' s crotch. PTA stated he told CNA 1 at the time of the incident, and she separated them. PTA stated he did not report the incident to anyone else except CNA 1. PTA stated he thinks someone from the Social Services Department questioned him about the incident after but never heard about it again.</p> <p>During a review of Resident 5 ' s ADMISSION RECORD (AR), dated 9/19/24, the AR indicated, Resident 5 was a [AGE] year old female with diagnosis of intellectual disability (limitations in mental abilities affecting intelligence, learning and everyday life skills), lack of physiological development (the development of human beings cognitive, emotional, intellectual, and social capabilities and functioning over the course of a normal life span) in childhood, Functional quadriplegia (complete immobility due to severe disability or frailty from another medical condition) and cerebral palsy (affects a person's ability to move and maintain balance and posture).</p> <p>During a review of Resident 5 ' s MDS under the section BIMS, dated 6/11/24, the BIMS indicated, Resident 3 had a score of 99 (severely impaired cognition).</p> <p>During an interview on 9/18/24 at 9:44 a.m. with DON, DON stated she was not aware but if Resident 4 was observed placing Resident 5 ' s hand on his crotch the incident should have been reported to the state agency as a possible abuse.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility ' s job description titled, Director of Social Services, undated, the P&P indicated, The primary purpose of your job position is to plan, organize, develop, and direct the overall operation of our facility's Social Services Department in accordance with current federal, state, and local standards, guidelines and regulations, our established policies and procedures, and as may be directed by the Administrator, to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis. As Director of Social Services, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. Accurately document and investigate all reports of abuse according to the Abuse Prevention Policies and Procedures. Ensure the safety of residents at all times. Notify the DON and Administrator immediately of suspected abuse.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, ABUSE PREVENTION PROGRAM, dated 7/22/21, the P&P indicated, All alleged/suspected violations and all substantiated incidents of abuse will be promptly reported to the Ombudsman or law enforcement and CDPH as required by law and in accordance with this policy. Should an alleged/suspected violation or substantiated incident of mistreatment, neglect, injuries of unknown source be reported (in which abuse is suspected), the Nursing Supervisor or the Supervisor of the witness shall be responsible for completing an SOC 341 and reporting to the appropriate agency.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide or obtain dental services for each resident.</p> <p>37697</p> <p>Based on observation, interview, and record review, the facility failed to obtain dental services for two of eight sampled residents (Resident 6 and Resident 7). This failure had the potential to result in progressive oral health decline, oral pain, infection, and weight loss.</p> <p>Findings:</p> <p>During a review of Resident 6 ' 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 8/21/24, the BIMS indicated, Resident 6 had a score of 15 (cognitively intact).</p> <p>During a concurrent observation and interview on 9/12/24 at 11:18 a.m. with Resident 6 in his room, Resident 6 was observed to have multiple discolored dark brown to yellowed stained teeth specifically to his lower mouth. Some of the teeth appeared broken exposing the inner aspects of the tooth. Resident 6 ' s lower gums appeared red in color and swollen. Resident 6 stated he cannot get anyone to get him an appointment with the dentist. Resident 6 stated he talked to the social services (not sure when) about his need for dental services, but nothing happened. Resident 6 stated he was having pain to the teeth in the bottom portion of his mouth and the sides but does not get any pain medication for it. Resident 6 stated the pain is ten out of ten (10/10 - the worst pain possible). Resident 6 stated it hurts when he bites into food, and he had a gritty feeling in his mouth when he is eating. Resident 6 stated, I can ' t get anyone to help with social services and my teeth. Dealing with social services is like talking to the wall.</p> <p>During a review of Resident 8 ' s MDS under the section BIMS, dated 10/1/24, the BIMS indicated, Resident 8 had a score of 15.</p> <p>During an interview on 9/12/24 at 12:33 p.m. with Resident 8, Resident 8 stated she is the president of the resident council. Resident 8 stated during the residents council meeting (no date given) she heard a resident (unidentified) complaints about dentist not coming to check residents.</p> <p>During a review of the facility ' s Resident Council Report (RCR), dated 8/20/24, the RCR indicated, during resident council an unidentified resident requested he would like social services to look into his/her dental status and refer him/her.</p> <p>During an interview on 9/12/24 at 1:44 p.m. with Social Services Assistant (SSA), SSA stated Resident 6 was last seen by a dentist in April 2024 with recommendations for extractions (removal) of some of his teeth.</p> <p>(continued on next page)</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 9/12/24 at 2:35 p.m. with Business Clerk (BC), Resident 6 ' s DENTAL (DN), dated 4/18/24 was reviewed. The DN indicated Resident 6 required extractions (removal) of six of his teeth to his bottom mouth and one extraction of a tooth to the top of his mouth. BC stated after the dentist makes a recommendation for extractions the facility would submit a referral form to the resident ' s primary physician to sign an order to get medical clearance for the procedure. BN stated she had just started assisting the Social Services Department with referrals in July. BN was not sure who was assisting with referrals prior. BN stated Resident 6 ' s physician signed the forms required when she sent them on 8/5/24. BN stated she sent the forms to the dentist on 8/7/24 but has not followed up on the status. BN stated staff (not specific) were aware to follow up as well but has not heard anything from them about Resident 6.</p> <p>During a concurrent interview and record review on 9/12/24 at 2:35 p.m. with BC, Resident 7 ' s DENTAL (DN), dated 6/18/24 was reviewed. The DN indicated Resident 7 required oral surgery on four of his teeth. BN stated the recommendation was made on 6/19/24 but the referral was not sent until 8/29/24. BN stated referrals were to be done as soon as possible.</p> <p>During an interview on 9/12/24 at 3:18 p.m. with Director of Nursing (DON), DON stated referrals for medical clearance on residents needing dental care should be made the same day or the following business day. DON stated waiting months on a referral to be completed was too long. DON stated some complications for waiting too long on dental needs would be infection, bleeding, pain, and potential eating/weight issues.</p> <p>During a review of the facility ' s job description titled, Director of Social Services, undated, the P&P indicated, The primary purpose of your job position is to plan, organize, develop, and direct the overall operation of our facility's Social Services Department in accordance with current federal, state, and local standards, guidelines and regulations, our established policies and procedures, and as may be directed by the Administrator, to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis. As Director of Social Services, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. Manage and oversee ancillary services for all residents. Ensure compliance and record keeping. Manage complaints, concerns, and resident appointments as needed.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Dental Services for Residents, dated 6/22/09, the P&P indicated, PURPOSE: To ensure that dental services are made available to the residents as required and authorized by various statues. It is the policy of the facility to provide necessary routine and emergency dental care to each of the residents. The facility may charge a Medicare resident an additional amount for routine and emergency dental services. Emergency dental services includes services needed to treat an episode of acute pain in teeth, gums, or palate; broken, or otherwise damaged teeth, or any other problem of the oral cavity, appropriately treated by a dentist that requires immediate attention. Prompt referral means, within reason, as soon as the dentures are lost or damaged. Referral does not mean that the resident must see the dentist at that time, but does mean that as appointment (referral) is made, or that the facility is aggressively working at replacing the dentures.</p>		