

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  11/18/2024
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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37697</b></p> <p>Based on observation, interview, and record review, the facility failed to treat one of five sampled residents (Resident 1) with dignity and respect. This failure had the potential for emotional distress for Resident 1.</p> <p>Findings:</p> <p>During an interview on 11/18/24 at 9:51 a.m. with Director of Nursing (DON), DON stated on 11/9/24, Certified Nursing Assistant (CNA) 1 observed Restorative Nurse Assistant (RNA) 1 placed her hand over Resident 1's mouth as she was screaming to quiet Resident 1 down.</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 10/24/24, the BIMS indicated, Resident 1 had a score of 9 (cognition moderately impaired).</p> <p>During an interview on 11/18/24 at 11:09 a.m. with Resident 1, Resident 1 stated she could not recall the incident occurred on 11/9/24.</p> <p>During an interview on 11/18/24 at 12:15 p.m. with CNA 1, CNA 1 stated on 11/9/24 at approximately 10 a. m. she observed Resident 1 in her wheelchair coming out of her room and screaming, Help me. CNA 1 stated she then saw RNA 1 placed her hand over Resident 1's mouth to stop Resident 1 from screaming. CNA 1 stated Resident 1 was screaming help me through RNA 1's hand.</p> <p>During an interview on 11/18/24 at 12:40 p.m. with RNA 1, RNA 1 stated she and RNA 2 entered Resident 1's room to weigh her. RNA 1 stated Resident 1 began screaming in Spanish as she was wheeling herself out of the room. RNA 1 stated she did not cover Resident 1's mouth or touch her face to stop Resident 1 from screaming.</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 11/18/24 at 12:50 p.m. with DON, security camera footage for 11/9/24 in Resident 1's hall was observed. On the security footage at 9:56 a.m. Resident 1 was noted wheeling herself out of her room after RNA 2 exited with a weight machine. Resident 1 was followed out of the room by RNA 1 who placed her right hand over the mouth of Resident 1. Resident 1 was observed to slap the hand of RNA 1 off her mouth and RNA 1 then touches the right side of Resident 1's head with her right hand and then taps Resident 1's right shoulder twice. DON verified these observations and stated the facility investigation had been completed and both RNA 1 and RNA 2 will be terminated from what was observed on the security footage.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Dignity and Respect, dated 4/9/14, the P&amp;P indicated, The purpose is to provide a work environment and culture in which all employees including residents, and families, and visitors have the right be treated with dignity and respect, free from intimidation and harassment. Employees are expected to maintain a high standard of professional conduct at all times. Disparaging remarks, offensive language, or any behavior that undermines the dignity of others will not be tolerated. [NAME] District Skilled Nursing Facility has a zero-tolerance policy for any form of harassment, including but not limited to verbal, physical, sexual, or visual harassment.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>37697</p> <p>Based on observation, interview, and record review, the facility failed to implement their policy and procedure on Abuse Prevention Program for one of five sampled residents (Resident 1). This failure had the potential for further abuse to occur.</p> <p>Findings:</p> <p>During an interview on 11/18/24 at 9:51 a.m. with Director of Nursing (DON), DON stated on 11/9/24, Certified Nursing Assistant (CNA) 1 observed Restorative Nurse Assistant (RNA) 1 placed her hand over Resident 1's mouth in an attempt to stop Resident 1 from screaming.</p> <p>During an interview on 11/18/24 at 12:15 p.m. with CNA 1, CNA 1 stated on 11/9/24 at approximately 10 a. m. she observed Resident 1 in her wheelchair coming out of her room and screaming, Help me. CNA 1 stated she then saw RNA 1 placed her hand over Resident 1's mouth to stop her from screaming. CNA 1 stated Resident 1 was screaming help me through RNA 1's hand. CNA 1 stated she reported this allegation of abuse immediately to her supervisor.</p> <p>During a concurrent observation and interview on 11/18/24 at 12:50 p.m. with DON, security camera footage for 11/9/24 in Resident 1's hall was observed. On the security footage at 9:56 a.m. Resident 1 is seen wheeling herself out of her room after RNA 2 exited with a weight machine. Resident 1 was followed out of the room by RNA 1 who placed her right hand over the mouth of Resident 1. Resident 1 was observed to slap the hand of RNA 1 off her mouth and RNA 1 then touches the right side of Resident 1's head with her right hand and then taps Resident 1's right shoulder twice. DON verified these observations and stated the facility investigation had been completed and both RNA 1 and RNA 2 will be terminated from what was observed on the security footage. DON stated the incident occurred and was reported at approximately 10:00 a.m. but RNA 1 was not sent home until approximately 3:26 p.m. DON stated RNA 1 continued working with residents after the allegation of abuse with Resident 1 was made at approximately 10 a.m.</p> <p>During a review of the facility Timecard Detail Report with Signature (TDRS), dated 10/28/24 to 11/10/24, the TDRS indicated RNA 1 came into work on 11/9/24 at 6:38 a.m. and left work at 3:26 p.m. (approximately five hours and 26 minutes after allegation of abuse was reported).</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, ABUSE PREVENTION PROGRAM, dated 7/22/21, the P&amp;P indicated, Protection of Residents During Abuse Investigations . During abuse investigations, residents will be protected from harm by the following measures . Staff will ensure the immediate physical safety of the resident first by ensuring that the accused perpetrator is not near the resident. Staff will observe to ensure that both parties remain separated until further investigation. Employees accused of participating in the alleged abuse shall be placed on administrative leave until the Administrator, SSD (social services director) and/or DON has reviewed the results of the investigation. While the investigation is being conducted, accused individuals not employed by the facility shall be denied unsupervised access to residents. Visits may only be made in designated areas approved by the Administrator, DON, SSD, or designee. Employees of the facility who are suspected of resident abuse may be placed on administrative leave until the Administrator has reviewed the results of the investigation.</p>		