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	11/14/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement an effective discharge plan for one of three sampled residents (Resident 1) when Resident 1 was discharged home without home health services (where health care professionals provide health care services to the resident at his home) as ordered by the physician and failed to document a post-discharge plan of care in Resident 1's discharge summary. These failures had the potential to place Resident 1 at risk for not achieving his health care goals and preventable hospital and/or skilled nursing facility readmission.Findings:During a review of Resident 1's admission Record (AR), dated 11/14/25, the AR indicated Resident 1 was [AGE] years old, was admitted to the facility on [DATE] with diagnoses including generalized muscle weakness, difficulty walking, and unsteadiness on feet. The AR indicated Resident 1's Responsible Party (RP-the person who makes medical decisions on behalf of the resident) was Family Member (FM) 1.During a review of Resident 1's Physician Order (PO), dated 11/7/25 at 3:57 p.m., the PO indicated, Discharge to home on [DATE] @ [at] 9 AM with same meds [medications] and treatment with Around the Clock Home Health PT/OT/ST [Physical Therapy] [Occupational Therapy] [Speech Therapy] .During a review of Resident 1's Discharge Summary (DS), dated 11/9/25, the DS indicated, Your physician has requested the following as a part of your post-discharge treatment plan: PT [Physical Therapy] OT [Occupational Therapy] ST [Speech Therapy]. The DS indicated Resident 1 Requires Assistance with ambulation, transfers, toileting, dressing, bathing and grooming. The DS had no information how Resident 1 was to obtain PT/OT/ST. Resident 1's DS section titled Discharge Planning/Discharge Care Plan was blank.During a review of Resident 1's Progress Note (PN) dated 11/10/25 at 10:11 a.m., the PN indicated Follow up with [Home Health Agency].home health is unable to service resident's area.During a review of Resident 1's Progress Note (PN) dated 11/12/25 at 10:29 a.m., the PN indicated Resident 1's insurance informed they did not have in-network [contracted with them] home health agencies in the area Resident 1 lived in and that Resident 1 needs to go out of network with another doctor in his area so he can obtain home health services in his area. During an interview with FM 1 on 11/14/25 at 10:55 a.m. FM 1 stated Resident 1 had been discharged to his care and was living with him. FM 1 stated he could not care for Resident 1, that Resident 1 was physically weak and that Resident 1 could not independently complete activities of daily living. FM 1 stated Resident 1 stayed seated on a sofa chair in the living room the whole day. FM 1 stated nobody had come to provide any health care to Resident 1.During an interview on 12/22/25 at 9:30 a.m. with the Director of Nursing (DON), DON stated Resident 1 had been admitted [DATE] for PT/OT/ST and was discharged home on [DATE] because his health insurance denied skilled nursing facility coverage past 11/9/25. DON stated Resident 1's PO indicated Resident 1 to receive PT/OT/ST at home provided by a home health agency. DON stated the facility could not arrange home health services to Resident 1 because no home health agency provided services where Resident 1/FM 1 lived in. DON stated Resident 1 was discharged home on [DATE] with no home health care services.During an interview with the Social Services Assistant (SSA) on 12/22/25 at 10:07 a.m. SSA stated Resident 1 was ordered to be discharged with home health services, but she could not find a home health agency servicing the area Resident 1 lived in. SSA stated We tried home health, and nobody would service that area. SSA stated she contacted Resident 1's insurance company and was advised that Resident 1 needed to seek an out of network home health agency that serviced the area he lived in. SSA stated she informed FM 1 of the above but stated I don't think he understood. SSA stated Resident 1 was discharged to the care of FM 1 on 11/9/25 with no home health services.During a review of the facility's policy and procedure (P&P) titled, Discharge Documentation, dated 3/9/23, the P&P indicated, When a discharge is anticipated, the resident will have a discharge summary which includes a. a post-discharge plan of care. which will assist the resident to adjust to his/her new living environment.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:1. Provide discharge notice before discharging one of three sampled residents (Resident 1) to include the reasons for discharge. This failure had the potential for Resident 1 being discharged inappropriately and not prepared for his discharge.2. Send a copy of the notice of discharge to the Office of the State Long-Term Care Ombudsman (Ombudsman-an elderly advocacy agency) for 12 of 13 residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11 and Resident 12). This failure had the potential to prevent the Ombudsman from assisting and advocating for Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11 and Resident 12 during their discharge process.Findings:During a review of Resident 1's admission Record (AR), printed 11/14/25, the AR indicated Resident 1 was [AGE] years old was admitted to the facility on [DATE] with diagnoses including generalized muscle weakness, difficulty walking, and unsteadiness on feet. The AR indicated Resident 1's Responsible Party (RP) (the person who makes medical decisions on behalf of the resident) was Family Member (FM) 1.During a review of Resident 1's Physician Order (PO), dated 11/7/25 at 3:57 p.m., the PO indicated: Discharge to home on [DATE] @ 9 AM with same meds [medications] and treatment with Around the Clock Home Health PT/OT/ST [Physical Therapy] [Occupational Therapy] [Speech Therapy].During a review of Resident 1's Notice of Proposed Transfer/Discharge (ND), dated 11/9/25, the ND indicated the Resident 1 was being discharged because the resident's health had improved sufficiently that he no longer needed the services provided by the facility. The ND indicated the ND was provided to FM 1 on 11/9/25 (on the day of discharge).During an interview on 12/22/25 at 9:30 a.m. with the Director of Nursing (DON), DON stated Resident 1discharge order was written on 11/7/25 and Resident 1 was discharged on 11/9/25. DON stated the ND was provided to FM 1 on 11/9/25.During an interview with the Social Services Assistant (SSA) on 12/22/25 at 10:07 a.m., SSA stated the ND was provided to FM 1 on 11/9/25 (the day of discharge) and not on 11/7/25 (the day Resident 1's physician signed his discharge order) because FM 1 was not at the facility on 11/7/25 and only came to the facility on [DATE]. SSA stated FM 1 was verbally informed of the discharge on [DATE] and on 11/5/25 when the Notice of Non Medicare Coverage (NUMNOC) was given to him.2. During a concurrent interview and record review with the SSA on 12/22/25 at 10:07 a.m., SSA stated she did not send copies of residents' ND's to the Ombudsman. SSA provided a copy of document titled Discharge Control and Task Log (Discharge Log) dated 11/14/25. The Discharge Log indicated the following:Resident 2 discharged on 11/1/25Resident 3 discharged on 11/3/25Resident 4 discharged on 11/4/25Resident 5 discharged on 11/4/25Resident 6 discharged on 11/4/25Resident 7 discharged on 11/5/25Resident 8 discharged on 11/5/25Resident 9 discharged on 11/6/25Resident 10 discharged on 11/7/25Resident 1 discharged on 11/9/25Resident 11 discharged on 11/10/25Resident 12 discharged on 11/11/25During a review of email communication dated 12/22/25 at 2:01 p.m., the Ombudsman stated they did not receive Resident 1's ND. The Ombudsman stated the facility did not send them the NDs. The Ombudsman denied informing the facility not to send them NDs. The Ombudsman stated the facility only sent them a list of residents discharged and list contained only the name, admission and discharged dates and where the residents were discharged to. The Ombudsman stated their office had previously notified the facility in writing to send them NDs of all residents to be discharged . The Ombudsman provided copy of a letter sent to the facility on 8/22/25 indicating the facility's requirement to send NDs of all discharged residents to the Ombudsman.During a review of facility policy and procedure (P&P) titled Transfer and Discharge Notice, dated 2/25/10, the P&P indicated: Facility-initiated Transfer and Discharges: Notice of Transfer/Discharge is required. a written notice of discharge must be provided to the resident and the resident representative with a copy to the State LTC Ombudsman at least 30 days prior to the discharge or as soon as possible. The copy of the notice to the Ombudsman must be sent at the same time notice is provided to the resident and resident representative.