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	01/06/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) call light was placed within reach. This failure had the potential for Resident 1's unmet care needs.Findings:During a concurrent observation and interview, on 1/6/26 at 1:55 p.m. with Resident 1, in resident 1's room, Resident 1 was lying in bed with the head of the bed elevated. Resident 1 stated, They (certified nursing assistant [CNA]) do not give me my call light.During an observation on 1/6/26 at 2:36 p.m. outside of Resident 1's room, Resident 1 was heard yelling, CNA I don't have a call button. Resident 1 continued to call out for a CNA until 2:43 p.m.During a concurrent observation and interview, on 1/6/26 at 2:43 p.m. with CNA 4, in Resident 1's room, Resident 1 was lying in bed with the head of bed elevated. Resident 1's call button was looped to the bed rail but was hanging behind the top right-hand side of the mattress. CNA 1 stated Resident 1 could not reach the call light. CNA 1 stated the call light should be in easy reach for the residents. During a review of the facility's policy and procedure (P&P) titled, Call Light - Answering, reviewed 4/25/14, the P&P indicated, The purpose of this policy is to meet the residents' needs and requests within an appropriate time frame. It is the only mechanism at the resident's bedside whereby residents are able to alert nursing personnel to their needs. Each resident receives directions upon admission on how to use the call light system and where the call light is positioned at the bedside. All residents will have a call light in-place at all times.

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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure allegations of abuse were reported and investigated timely for one of three sampled residents (Resident 1). This failure resulted in a delay in reporting and Resident 1 not to be protected from further abuse.Findings:During a review of Resident 1's Minimum Data Set, (MDS - an assessment tool) dated 10/28/25, the MDS indicated, Resident 1' s BIMS (Brief Interview for Mental Status- standardized assessment tool used to evaluate the mental processes that allow individuals to think, learn, and remember) score was 15 (13 to 15 points indicates the resident has cognitive intactness).During a review of Resident 1's SBAR (situation, background, appearance, and review) Communication Form, (SBAR) dated 12/21/25, the SBAR indicated, Attention brought by CNA (Certified Nursing Assistant) that resident sustained a skin tear (an acute, traumatic wound where the top layers of skin separate from the underlying tissue due to friction, shearing, or blunt force) while changing her and doing ADLs (Activities of Daily Living - basic self-care tasks like bathing, dressing, toileting, and eating), resident had accidentally was bumped on side rail.During a review of Resident 1's Special Problems, (SP) dated 12/21/25, the SP indicated, (Resident 1) screamed Ouch you (expletive) you hit me told her I didn't hit you, you hit yourself with the siderail the SP was signed by CNA 3.During a review of Resident 1's Nurse's Notes, (NN) dated 12/23/25, the NN indicated, SOC 341 was filled due to resident claiming that she was hit on the right hand and sustained a skin tear during ADLs.During a concurrent observation and interview, on 1/6/26 at 1:55 p.m. with Resident 1, Resident 1 stated on 12/21/25, two CNAs were providing care. Resident 1 stated one of the CNAs was gripping and told her she screamed too much, and she should say please and thank you. Resident 1 stated her hand was injured during care and she told the CNAs you hit me. Resident 1's right hand was noted with a scab the size of a dime over the pinky finger knuckle.During an interview on 1/6/26 at 3:30 p.m. with CNA 2, CNA 2 confirmed she cared for Resident 1 on 12/21/25. CNA 2 stated she requested CNA 3 to assist with care for Resident 1. CNA 2 stated during care Resident 1 was injured and stated Resident 1 hit herself on the bedrail causing a skin tear. CNA 2 stated, (Resident 1) told us (CNA 2 and CNA 3) ouch you hit me, and we (CNA 2 and CNA 3) just said we did not hit you.During an interview on 1/6/26 at 3:49 p.m. with the Director of Nursing (DON), DON stated Resident 1 made allegations to CNA 2 and CNA 3 that CNA 2 and CNA 3 hit Resident 1. DON stated CNA 2 and CNA 3 did not report Resident 1's allegations. DON stated CNA 2 and CNA 3 were trained on how to report allegations of abuse.During an interview on 1/7/26 at 1:54 p.m. with CNA 3, CNA 3 stated on 12/21/25 she assisted CNA 2 with Resident 1's care. CNA 3 stated Resident 1 was injured during care, and she made an allegation that CNA 2 and CNA 3 hit her. CNA 3 stated, (Resident 1) told us you hit me, we told her no we did not, you hit the rail. CNA 3 stated she did not report Resident 1's allegations of abuse because I know people her age say things and I felt like she was mad.During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention Program, revised 7/22/21, the P&P indicated, 4. 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: a. The Resident's Responsible Party; b. The Resident's attending physician; c. The Ombudsman or Local Law Enforcement; and d. CDPH . 5. Notices to the above agencies/individuals must be submitted by telephone or confirmed fax within 24 hours from the time the incident occurred utilizing the SOC 341 form. 13. A person shall not knowingly; . Fail to report an incident of mistreatment or other offense; . The facility will protect residents from harm during investigations of abuse allegations. 1. During abuse investigations, residents will be protected from harm by the following measures: a. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. If a Resident sustained no serious bodily injury: Within 24 hours: Report the incident by phone to law enforcement. Within 24 hours: Submit a completed SOC 341 to the Ombudsman, law enforcement, and CDPH.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) wound was treated by a licensed nurse. This failure had the potential for allergic reaction (an immune system [a complex network of cells tissues and organs that defend against bacteria] overreaction to a harmless substance, causing symptoms ranging from mild to severe, and life-threatening) and/or infection (occurs when harmful bacteria enter the body, multiply, and trigger an immune response) for Resident 1.Findings:During an interview on 1/6/26 at 3:30 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated during care Resident 1 got a skin tear (an acute, traumatic wound where the top layers of skin separate from the underlying tissue due to friction, shearing, or blunt force) and CNA 3 went to the treatment nurse and got a triple antibiotic ointment (a combination of three medications used to treat or prevent infections in minor cuts and scrapes, to promote faster healing by stopping bacterial growth) and a pad to clean the skin tear and a band aid. CNA 3 cleaned Resident 1's skin tear and applied the triple antibiotic ointment placed the band aid on Resident 1's skin tear.During an interview on 1/6/26 at 3:56 p.m. with Director of Nursing (DON), DON stated CNAs are not allowed to do wound treatments.During a review of Resident 1's Special Problems, (SP) dated 12/21/25, the SP indicated, accidently hitting her against the side rail went to get a bandage for her & some ointmen [sic] antibiotic & I apply it on (Resident 1) . signed by CNA 3.During an interview on 1/7/26 at 1:54 p.m. with CNA 3, CNA 3 stated Resident 1 received a skin tear during care. CNA 3 stated she went and told the treatment nurse; the treatment nurse gave her ointment and a band aid. CNA 3 stated she applied the ointment and the band aid to Resident 1's skin tear.During a review of the facility's policy and procedure (P&P) titled, Medication Administration Schedule, revised 10/19/22, the P&P indicated, Medications are administered as prescribed in accordance with manufacturers' specification, good nursing principles and practices only by persons legally authorized to do so. Medications are prepared only by the licensed nurse, pharmacy or other personnel authorized by the state regulations to prepare and administer medications.