| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555479 | A. Building<br>B. Wing | 03/24/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Delano District Skilled Nursing Facility | 1509 Tokay Street<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:Supervise one of three sampled residents (Resident 1) after Resident 1 attempted to commit suicide (when a person intentionally harms themselves with the goal of ending their life, and they die as a result). This failure resulted in Resident 1's second suicide attempt.Follow their policy and procedure for Suicide Prevention Guidelines, to monitor one of three sampled residents (Resident 1) after Resident 1 attempted to commit suicide. This had the potential for Resident 1 to successfully kill herself and/or harm herself.Findings:During a review of Resident 1's admission RECORD (AR), dated 3/25/26, the AR indicated, Resident 1 was admitted to the facility on [DATE] with a diagnosis of schizoaffective disorder (a chronic mental health condition which causes people to lose touch with reality, such as hearing voices or holding false beliefs, while also experiencing intense mood swings) bipolar type (a mental health condition characterized by extreme, often unpredictable shifts in mood, energy, and activity levels), cognitive communication deficit (difficulty with communication resulting from problems with memory, attention, or brain function), anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life), and major depressive disorder (a serious mental health condition characterized by persistent, overwhelming sadness and a loss of interest in activities, lasting at least two weeks).During a review of Resident 1's Minimum Data Set (MDS) Assessment (a standardized assessment to evaluate a resident's functional abilities and healthcare needs), dated 1/15/26, under the section titled, Brief Interview for Mental Status (BIMS - an assessment of cognition [how well a person thinks, remembers, and learns]), the BIMS score was 14 (cognitively intact status).During a review of the facility 5 Day Investigation Summary (5DIS), dated 3/19/25. the 5DIS indicated, Resident 1 required a foley catheter (FC - tube inserted into the body to drain urine) for a diagnosis of urinary retention (the inability to empty the bladder [[NAME] like portion of the body that holds urine] meaning urine stays trapped inside even when you feel the need to pee).1. During an interview on 3/24/26 at 1:05 p.m. with Director of Nursing (DON), DON stated Resident 1 attempted to commit suicide in her room on 3/14/26 (no approximate time given) by using her call light (corded device used to call nurses for assistance). DON stated Resident 1 was placed on every 30-minute visual checks on 3/14/26 and 3/15/26 to monitor for any further suicide attempts. DON stated on 3/16/26 (two days after the suicide attempt) she had Resident 1 placed on one-to-one visual monitoring (one staff member dedicated to watching one specific resident at all times) when staff informed her Resident 1 attempted another suicide using her FC (3/14/26). DON stated she changed the 30-minute visual checks to one-to-one visual monitoring because Resident 1 attempted to commit suicide twice, first time using her call light and second time using her FC to wrap around her neck the same day on 3/14/26.During a review of Resident 1's Progress Notes (PN), dated 3/16/26 at 9 a.m., the PN indicated, on 3/14/26 regarding (Resident 1's) attempt to harm herself by wrapping the call light and FC catheter (sic) tubing around her neck. (Resident 1) pulled out her foley catheter and used it to harm herself . (Resident 1) has been on suicide watch since 3/14/26. FC is necessary to manage her<br>(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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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | bladder function and prevent hydronephrosis (the swelling of a kidney [portion of the body that creates urine] caused by a backup of urine), urinary tract infection [an infection of the urine] and possible kidney injury. (Resident 1) was assigned a 1:1 sitter to monitor for any suicide attempts which includes monitoring any attempts of pulling out her foley catheter . The PN did not indicate Resident 1 had made several attempts to commit suicide. During an interview on 3/24/26 at 1:59 p.m. with Resident 1, Resident 1 stated I don't want to hurt myself, I want to kill myself . I want to hurt myself but don't know how, if I had a gun I could do itDuring an interview on 3/24/26 at 2:32 p.m. with Registered Nurse (RN)1, RN stated on 3/14/26 she was called (cannot recall at what time) by Certified Nursing Assistant (CNA) 1 regarding Resident 1 attempting to commit suicide using her call light and FC. RN 1 stated she went into Resident 1's room and heard Resident 1 stated she wanted to kill herself. RN 1 stated she notified the DON on 3/14/26, regarding the suicide attempt made by Resident 1 using her call light and FC.During an interview on 3/27/26 at 10:02 a.m. with CNA 1, CNA 1 stated on 3/14/26 she was working the p.m. shift (2 p.m. to 10:30 p.m.) and was assigned to Resident 1. CNA 1 stated at approximately 4:30 p.m. she entered Resident 1's room due to hearing Resident 1 screaming. CNA 1 stated she saw Resident 1 with her call light wrapped around her neck (first attempt) but not her FC. CNA 1 stated she reported this to Licensed Vocational Nurse (LVN) 1. CNA 1 stated LVN 1 and another nurse (not identified) went into Resident 1's room and asked her to attend to the other residents while they assessed Resident 1. CNA 1 stated approximately 10 minutes later (4:40 p.m.) she heard Resident 1 screaming again. CNA 1 stated she entered Resident 1's room and noticed there were no staff in the room and Resident 1 had removed her FC and placed it around her neck in order to try to kill herself (second attempt).During an interview on 4/9/26 at 3 p.m. with LVN 2, LVN 2 stated she had worked the night shift (10:30 p.m. to 7 a.m.) on 3/14/26. LVN 2 stated Resident 1 was on every 30-minute visual checks (not one-to-one monitoring) the night after attempting to commit suicide. LVN 2 stated she had wondered why Resident 1 was on 30-minute visual checks but not one-to-one due to her attempts of killing herself. LVN 2 stated Resident 1 was not placed on one-to-one monitoring until Monday (3/16/26).During an interview on 4/15/26 at 2:08 p.m. with LVN 1, LVN 1 stated she was assigned to Resident 1 on 3/14/26. LVN 1 stated she was called into Resident 1's room (cannot recall the time) by CNA 1 and found Resident 1 with her call light wrapped around her neck in an effort to kill herself the first time. LVN 1 stated she called RN 1 regarding the incident and both her and RN 1 removed the call light and any other string/cords in the room so Resident 1 could not use them to harm herself. LVN 1 stated she left Resident 1's room to continue her work with other residents, assuming Resident 1 would be supervised by RN 1 or CNA 1. LVN 1 stated some time had passed (does not recall how much time passed) and she heard CNA 1 yelling out for her again. LVN 1 stated when she reentered Resident 1's room she observed Resident 1 with her FC around her neck in an attempt to commit suicide a second time. LVN 1 stated she thought it was to her understanding CNA 1 or RN 1 would be told to stay in Resident 1's room to monitor Resident 1. LVN 1 stated I knew she (Resident 1) was a danger to herself and needed to be monitored to prevent from harming herself. I did not get confirmation on who was going to keep an eye on her. I felt she needed to go out to the hospital for evaluation for 5150 (process in which qualified individuals can determine a person is a danger to themselves and/or others and can have them detained [to be temporarily held] for up to 72 hours for mental health evaluation and/or treatment).During an interview on 4/15/26 at 3:08 p.m. with DON, DON stated she was not aware Resident 1 attempted to commit suicide twice on 3/14/26. DON stated she thought Resident 1's call light and FC were used at the same time and not on separate suicide attempts. DON stated if she knew about the FC and Resident 1 had attempted to kill herself twice, I would have placed her (Resident 1) on one-to-one that night (3/14/26.) DON stated Resident 1 was not placed on one-to-one monitoring until 3/16/26.2. During a concurrent interview and record review on 3/24/26 at 4:09 p.m. with DON, the facility document titled Observation of Resident: Suicidal Ideation/Suicidal Attempts (ORSISA), dated 3/21/26 was reviewed. The ORSISA on 3/21/26 indicated Resident 1 was to be monitored every 30<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | minutes. The ORSISA indicated Resident 1 was not monitored at 11 a.m., 3 p.m., and 3:30 p.m. DON stated Resident 1 should have been monitored at these times to ensure Resident 1 was not harming herself.During a review of the facility's policy and procedure (P&P) titled, Suicide Prevention Guidelines, dated 3/3/23, the P&P indicated, The facility must provide medically related social services to attain the highest practicable physical, mental, and psychosocial well-being of each resident. In this respect, residents who threaten to harm themselves will be provided immediate attention to prevent such an occurrence. Notice will be made immediately to the physician, family and/or legal representative when residents threaten or attempt to harm themselves. In the event of a suicidal ideation, threat, gesture, or attempt, the first responder shall ensure the safety of the resident and notify the Charge Nurse. The Charge Nurse shall notify the Director of Nurses (DON), Director of Social Services, Administrator, family, and the physician. If needed, the resident will be relocated to an area that is closely monitored by staff. Nursing staff will monitor the resident every 30 minutes and provide documentation utilizing Attachment A (ORSISA). Documentation will also include inspection of resident's room for harmful objects every shift. If suicide threats increase, resident will be closely monitored until physician has been contacted and orders have been received. Documentation will continue during the period that suicidal ideations, threats, gestures, or attempts have been reported. Documentation may discontinue after three days of no recorded behaviors if agreed by IDT or physician. Medical Records staff will monitor the end of the documentation period. |

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| F 0943<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.<br><br>Based on interview and record review, the facility failed to ensure one of two sampled staff (Certified Nursing Assistant [CNA]) 1, completed annual abuse training. This failure had the potential to put residents at risk for abuse.Findings:During a review of Resident 1's IDT (Interdisciplinary Team- group of professionals from different disciplines who work together toward common, patient-centered goals) Notes dated 3/16/26, the IDT indicated, Responsible party.reported.(Resident 1) complained that a nurse (Certified Nursing Assistant [CNA] 1) from the NOC (night) shift was rude and mean.During a concurrent interview and record review on 3/17/26 at 1:55 p.m. with Human Resource Assistant (HRA), CNA 1's abuse training dated 2/7/23 was reviewed. The abuse training indicated CNA 1 last received training on 2/7/23 (more than three years prior) HRA was unable to provide more recent abuse training for CNA 1.During an interview on 3/17/26 at 2:05 p.m. with Administrator, Administrator stated that abuse training should have been completed annually.During an interview on 4/8/26 at 3:05 p.m. with Director of Staff Development (DSD), DSD stated abuse training should have been completed annually.During an interview on 4/13/26 at 4:15 p.m. with CNA 1, CNA 1 stated her last abuse training completed prior to the allegation was completed on 2/7/23. During a review of the facility's policy and procedure (P&P) titled Abuse Prevention Program dated 7/22/2021, the P&P indicated, In-Service Training.All new employees are required to attend the facility's resident rights and abuse prevention in-service training during their orientation.Training shall be provided on an annual basis and as needed. |