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	02/06/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42744 Based on observation, interview, and record review, the facility failed to ensure for five of 72 sampled residents (Resident 47, Resident 86, Resident 96, Resident 105, Resident 92) call lights were answered promptly. This failure had the potential to result in residents' unmet needs. Findings: During a concurrent observation and interview on 2/4/25 at 9:30 a.m. in Resident 47's room, Resident 47's call light was on. Resident 47 stated she needed some help from her Certified Nursing Assistant (CNA) because she had a dirty brief. During a concurrent observation and interview on 2/4/25 at 9:31 a.m. in the hallway outside of Resident 47's room, a light was on above Resident 47's door indicating her call light was on. CNA 4 was observed walking past the call light and going in and out of rooms on the opposite side of the hallway. CNA 4 stated she was new to the facility and was not sure which CNA was assigned to Resident 47's side of the hallway. During an observation on 2/4/25 at 9:35 a.m., CNA 4 entered Resident 47's room, was heard telling Resident 47 give me one second, and left the room without changing Resident 47's brief. CNA 4 proceeded to get the Hoyer lift and walk into room [ROOM NUMBER] at the end of the hallway. During an observation on 2/4/25 at 9:40 a.m. in the hallway outside of Resident 47's room, Resident 47's call light was on and a nurse wheeling the medication cart passed the room without answering the call light. During a concurrent observation and interview on 2/4/25 at 9:43 a.m. in Resident 47's room, CNA 1 answered Resident 47's call light. CNA 1 stated CNAs try to get to residents as soon as possible but if another CNA can't get to them, we should get them whatever they need. CNA 1 stated residents with dirty briefs needed to be changed right away. During an interview on 2/4/25 at 10:35 a.m. with Resident 47, Resident 47 stated CNAs have told her she is too needy and should not ring her call light so much. Resident 47 stated CNAs have told her they have to spend all their time taking care of her, so they don't have time with other residents. 34510 (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

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	02/06/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/25 at 10:22 a.m. with Resident 105, Resident 105 stated when the call light took too long for staff to answer, she felt desperate. During a review of Resident 105's Minimum Data Set (MDS- comprehensive assessment tool), dated 1/16/25, the MDS indicated, Resident 105 had a Brief Interview for Mental Status (BIMS- cognitive assessment) score of 15 (score of 13-15 means cognitively intact). Resident 105's MDS indicated, Resident 105 required partial/moderate assistance (helper does more than half the effort) with activities of daily living. During an interview on 2/4/25 at 10:22 a.m. with Resident 92, Resident 92 stated it takes staff more than 15 minutes for staff to answer the call light. Resident 92 stated she felt frustrated. During a review of Resident 92's MDS, dated [DATE], the MDS indicated, Resident 92 had a BIMS score of 15. Resident 92's MDS indicated, Resident 92 required supervision or touching assistance (helper provides verbal cues). 37797 During a concurrent observation and interview on 2/3/25 at 2:29 p.m. with Resident 96, Resident 96 stated she needed to be changed and pressed the call light. The call light was answered at 2:44 p.m. During an interview on 2/4/25 at 8:30 a.m. with Resident 86, Resident 86 stated she and other residents routinely waited 15 minutes or more for call lights to be answered, which was too long. During an interview on 2/6/25 at 2:36 p.m. with Administrator, Administrator stated, If you are passing a light, you should be answering that light. Administrator stated a 15-minute delay in answering a call light is not prompt. During a review of the facility's policy and procedure (P&P) titled, Call Light- Answering, dated 4/25/14, the P&P indicated, PURPOSE: 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. PROCEDURE: NURSING ACTION . 5. Staff will observe call lights. 6. Answer all lights promptly, regardless of whose resident it is.

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	02/06/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42744 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS- a standardized assessment tool that measures the health of nursing home residents) was accurate for one of one sampled resident (Resident 139). This failure resulted in an inaccurate medical record regarding Resident 139's discharge location. Findings: During a concurrent interview and record review on 2/6/25 at 1:29 p.m. with MDS Coordinator (MDSC), Resident 139's MDS was reviewed. The MDS indicated, Resident 139 was admitted to the facility on [DATE] and discharged on [DATE]. MDS Section A2105 indicated Resident 139 was discharged to a short-term general hospital for acute care. MDSC stated Resident 139 was discharged to a short-term general hospital based on the MDS. MDSC stated the MDS was completed by the Social Services Director on 12/31/24. During a concurrent interview and record review on 2/6/25 at 1:32 p.m. with MDSC, Resident 139's Nurse's Notes, (NN) dated 12/20/24 were reviewed. The NN indicated, Resident was discharged to home . in stable condition. MDSC stated the MDS was not accurate because Resident 139 was discharged home and not to a hospital. MDSC stated the MDS should have been accurate. During a concurrent interview and record review on 2/6/25 at 1:42 p.m. with MDSC, CMS [Centers for Medicare & Medicaid Services] RAI [Resident Assessment Instrument- assists staff in comprehensively assessing residents] Version 3.0 Manual, (RAI Manual) dated 10/24 was reviewed. The RAI Manual Section Z0400 indicated, If an individual who completed a portion of the MDS is not available to sign it . there are portions of the MDS that may be verified with the medical record and/or resident/staff/family interview as appropriate. For these sections, the person signing the attestation must review the information to assure accuracy and sign for those portions on the date the review was conducted. MDSC stated the facility did not have a policy and procedure for MDS accuracy but followed the RAI Manual. MDSC stated she had not reviewed Resident 139's MDS Section A2105 for accuracy and had attested the section was accurate, even though it was not accurate based on the medical record.

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	02/06/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 42744 Based on observation, interview, and record review, the facility failed to ensure fluids were accessible at the bedside for one of eight sampled residents (Resident 47). This failure had the potential to result in Resident 47 not having sufficient fluid intake to maintain proper hydration. Findings: During a concurrent observation and interview on 2/4/25 at 10:33 a.m. in Resident 47's room, the bedside table containing a water pitcher and cup was located next to the window across from the bed and not within Resident 47's reach. No straw was observed on the bedside table. Resident 47 stated she could drink water by herself if a straw was available. Resident 47 stated she had been having diarrhea. During a concurrent observation and interview on 2/4/25 at 10:49 a.m. with Registered Nurse (RN) 3, Resident 47's bedside table containing her water pitcher and cup was observed to be located next to the window across from the bed. RN 3 stated the bedside table should be within Resident 47's reach. RN 3 stated Resident 47 was at risk for dehydration, especially since she was having diarrhea. During a review of Resident 47's Care Plan (CP), (undated), the CP indicated, The resident had potential fluid deficit. During a review of the facility's policy and procedure (P&P) titled, Hydration, dated 10/6/15, the P&P indicated, PURPOSE: To ensure that each resident is provided with the necessary fluids for adequate hydration based upon assessed daily fluid needs . POLICY STATEMENTS . The facility will identify resident's [sic] with risk factors such as vomiting/diarrhea resulting in fluid loss . PROCEDURE: 1. GENERAL . e. Each resident will be provided a container of fresh water and a clean cup or glass near the bedside at all times.

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	02/06/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44134 Based on observation, interview, and record review, the facility failed to monitor two of two sampled residents (Resident 18 and Resident 41) oxygen saturations (how much oxygen is in the blood). This failure had the potential for Resident 18 and Resident 41 to not receive oxygen as ordered and become hypoxic (low levels of oxygen in the blood that can cause headache, difficult breathing, confusion and increased rate of breathing). Findings: During an observation on 2/3/25 at 9:14 a.m. in Resident 18's room, Resident 18 was laying in bed with eyes closed. Resident 18 was not wearing oxygen. During an observation on 2/4/25 at 8:40 a.m. in Resident 18's room, Resident 18 was laying in bed with eyes closed. Resident 18 was not wearing oxygen. During a concurrent interview and record review on 2/5/25 at 9:19 a.m. with Registered Nurse (RN) 2, Resident 18's Order Summary Report (OSR), dated 2/5/25 was reviewed. The OSR indicated, O2 [oxygen] INHALATION [breathing in] AT 2 LPM [liters per minute] VIA [by] NASAL CANNULA [flexible tube with two prongs that are inserted into the nostrils to deliver oxygen] PRN [as needed] FOR O2 SAT [saturation] < [less than] 93 % [percent] had been ordered for Resident 18 on 10/20/23. RN 2 stated, When we notice shortness of breath, we check the O2 sats and apply it [oxygen]. During a concurrent interview and record review on 2/5/25 at 9:20 a.m. with RN 2, Resident 18's Electronic Medication Administration Record (EMAR), dated January 2025 and February 2025 were reviewed. RN 2 stated Resident 18's oxygen saturations had not been documented. RN 2 stated Resident 18's oxygen saturations should have been documented in the EMAR. During a concurrent interview and record review on 2/6/25 at 11:41 a.m. with Director of Nursing (DON), Resident 18's OSR, dated 2/5/25 was reviewed. The OSR indicated, O2 INHALATION AT 2 LPM VIA NASAL CANNULA PRN FOR O2 SAT <93%. DON stated, When we have this order, we check the patient to see if they are having a hard time breathing or gasping for air and then we would check the residents oxygen saturation and if it was below 93%, they would give oxygen. DON stated not all residents with low oxygen levels are short of breath. DON stated Resident 18 should have had oxygen saturation monitoring to indicate when oxygen needed to be applied per physician order. During an interview on 2/6/25 at 11:47 a.m. with DON, the facility's policy and procedure for monitoring oxygen saturation was requested. DON stated they do not have a policy; they only follow physician orders. 42744 (continued on next page)

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	02/06/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/25 at 3:06 p.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated a resident's vital signs (VS) should be taken every eight hour shift. CNA 3 stated VS included blood pressure, heart rate, respirations, oxygen saturations, and temperature. CNA 3 stated if oxygen saturations were lower than 90%, then she would report this to the nurse. CNA 3 stated she would document the VS in the electronic medical record (eMR) and on paper. During a concurrent interview and record review on 2/5/25 at 3:17 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 41's eMR summary of oxygen saturations were reviewed. Resident 41's eMR indicated, missing oxygen saturations for all three shifts on 1/30/25, 1/31/25, 1/1/25, and 1/2/25. Resident 41's eMR indicated, missing oxygen saturations for night shift and evening shift on 2/4/25. LVN 2 stated VS included blood pressure, temperature, pulse, respirations, oxygen saturations, and pain level and should be taken every shift. LVN 2 stated Resident 41's oxygen saturations were not documented in the eMR and stated they should have been. During a concurrent interview and record review on 2/6/25 at 1:55 p.m. with Director of Nursing (DON), Resident 41's Physician Order (PO), dated 1/26/25 was reviewed. The PO indicated, Continuous oxygen inhalation @ [at] 2-3/LPM via nasal cannula, every shift for SOB [shortness of breath] or if oxygen saturation less than 92%. DON stated the facility process was to follow physician orders. DON stated staff visually assessed residents for SOB. DON stated nursing staff probably need to monitor oxygen saturations. During an interview on 2/6/24 at 2:16 p.m. with Respiratory Therapist (RT), RT stated in a nursing home oxygen saturations are normally monitored once a shift. RT stated if oxygen saturations are less than 92% on room air then the resident needs oxygen. RT stated shortness of breath would not be the only assessment to perform if a resident had an oxygen order. RT stated heart rate, respiratory rate, oxygen saturations, level of consciousness, breath sounds, and position should be assessed for residents with oxygen orders.

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	02/06/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47095 Based on observation, interview, and record review, the facility failed to ensure Registered Nurse (RN) 1 had current cardiopulmonary certification (CPR-healthcare provider demonstrated training in life-saving intervention competency when loss of pulse and/or breathing in a medical emergency) as indicated in the facility's job description titled, Registered Nurse (RN) for one of 15 sampled RN's (RN) 1. This failure resulted in RN 1's CPR certification employment requirement not being met and had the potential for adverse vulnerable resident outcomes. Findings: During a concurrent interview and record review on [DATE] at 2:42 p.m. with Human Resource Manager (HRM), RN 1's employee file was reviewed. The employee file indicated RN 1's date of hire was [DATE]. HRM stated RN 1 did not have current CPR certification to meet RN employment requirement. During a concurrent observation and interview on [DATE] at 3:19 p.m. with RN 1, RN 1 was working in the facility's East wing. RN 1 stated she did not have a current CPR certification and her CPR expired last year [2024]. RN 1 stated current CPR certification was an RN job requirement and important in case of a medical emergency for residents. During a concurrent interview and record review on [DATE] at 3:32 p.m. with HRM, the facility's job description (JD) titled, Registered Nurse (RN), (undated) was reviewed. The JD indicated, Must have CPR license. HRM stated RN 1 did not have CPR certification and should have CPR certification per the RN job description requirement.

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	02/06/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37797 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of three of 27 sampled residents (Resident 93, Resident 128, and Resident 96) when: 1. Staff did not follow Resident 93's physician order to remove a Lidocaine patch (a pain medication applied directly to the skin) from Resident 93's back after 12 hours of application. This failure resulted in Resident 93 having Lidocaine applied for a period longer than prescribed. 2. Staff administered a Nifedipine Extended Release tablet (a medication to treat high blood pressure especially formulated to slowly release the drug into the bloodstream over an extended period and to be administered whole) crushed into a powder to Resident 128. This failure resulted in Resident 128 receiving Nifedipine at a higher dose than prescribed. 3. Staff failed to ensure Morphine and Methadone (controlled drugs with a high potential for abuse and addiction) prescribed for Resident 96 were properly accounted for. This failure resulted in Resident 96 at risk of having her Morphine and Methadone medications lost or diverted. 4. Staff failed to follow policy and procedure when the outgoing nurse of the East Wing signed the end of shift narcotic count sheet before the end of her shift and in the absence of the incoming nurse. This failure had the potential for residents having their controlled medications lost or diverted. Findings: 1. During a review of Resident 93's Admission Record (AR), dated 2/6/25, the AR indicated, Resident 93 was admitted on [DATE] with a principal diagnosis of dementia (decline in memory, thinking, and problem solving). During a review of Resident 93's Order Details (OD), (undated), the OD indicated, physician order dated 1/6/25 as follows: Lidocaine External Patch 4% (Lidocaine) Apply to LOWER BACK topically one time a day for PAIN (12 HOURS ON AND 12 HOURS OFF AND REMOVE PER SCHEDULE) and remove per schedule. During a review of Resident 93's Medication Administration Record (MAR), dated 2/1/25-2/28/25, the MAR indicated, Resident 93's Lidocaine Patch was to be applied daily at 8 a.m. and removed at 8 p.m. During a concurrent observation and interview on 2/5/25 at 8:26 a.m. with Registered Nurse (RN) 4, RN 4 stated she would apply Resident 93's Lidocaine Patch. RN 4 retrieved the Lidocaine patch from the medication cart. The label on the Lidocaine patch indicated, Apply 1 Patch to the affected area topically remove per schedule (12 hours on - 12 hours off). RN 4 raised Resident 93's shirt, exposed his back, stated let me remove the old patch, removed a patch of the same size and appearance from his lower back, and applied the Lidocaine patch to the same location. RN 4 stated the Lidocaine patch removed had been applied the previous day in the morning. (continued on next page)

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	02/06/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/6/25 at 9:10 a.m. with the facility's Consultant Pharmacist (CP), the CP stated staff should administer medications according to physician orders, and that Resident 93's Lidocaine patch should have been removed after 12 hours of application. During a review of facility's policy and procedure (P&P) titled, General Dose Preparation and Medication Administration, dated 1/27/21, the P&P indicated, . facility staff should . verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct time, for the correct resident, as set forth in the Facility Medication Administration Times Schedule . 2. During a review of Resident 128's AR, dated 2/6/25, the AR indicated Resident 128 was admitted on [DATE] with diagnoses including hypertension (high blood pressure) and dysphagia (difficulty swallowing). During a review of Resident 93's Medication Administration Record (MAR), dated 2/1/25-2/28/25, the MAR indicated, physician order dated 7/7/24 as follows: Crushed Medications according to facility policy and pharmacy recommendations and physician order dated 12/9/24 as follows: Nifedipine ER Osmotic Release Oral Tablet Extended Release 24 hours 30 MG (Nifedipine) Give 1 tablet by mouth one time a day . During a concurrent observation and interview on 2/5/25 at 8:38 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated she was going to administer medications to Resident 128. LVN 5 removed a tablet from the medication cart with the label Nifedipine 30 mg EXTENDED RELEASE 24 HOURS. LVN 5 crushed the tablet into a powder and gave it to Resident 128 mixed with food. LVN 5 stated Resident 128 took all his medications crushed. During a concurrent interview and record review on 2/6/25 at 9:10 a.m. with the CP, the CP reviewed Resident 128's medication orders and stated Nifedipine Extended Release tablets are designed to slowly release the drug over an extended time and for this reason should not be crushed and should be taken whole. The CP stated crushing Nifedipine Extended Release resulted in the resident receiving a higher dose of the medication than intended. During a review of the Food Drug Administration (FDA) document titled, PROCARDIA XL (nifedipine) Extended Release Tablets For Oral Use NDA 19684/S-023, dated February 2010, the document indicated: Information for Patients: Procardia XL Extended Release Tablets should be swallowed whole. Do not chew, divide or crush tablets. During a review of the facility's policy and procedure (P&P) titled, General Dose Preparation and Medication Administration, dated 1/27/21, the P&P indicated, Facility staff should only crush oral medications that can be crushed. 3. During a review of Resident 96's AR, dated 2/6/25, the AR indicated, Resident 96 was admitted on [DATE] for palliative care (end of life care). During a review of Resident 96's OD, (undated), the OD indicated, the following two medication orders for pain control: Morphine Sulfate Oral Solution 100 mg/5 ml *Controlled Drug* Give 10 mg sublingually every 6 hours for pain management. and Methadose Oral Concentrate 10 MG/ML (Methadone HCL) *Controlled Drug* Give 0.5 ml by mouth two times a day for pain management. (continued on next page)

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	02/06/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation, interview, and record review on 2/5/25 at 10:52 a.m. with RN 3 and LVN 4, RN 3 and LVN 4 provided the Controlled Drug Record sheets (Narcotic Logs) for February 2025 for Resident 96's morphine and methadone. RN 3 and LVN 4 stated each time a nurse administered those medications they documented in the Narcotic Log the dose administered and how much was left in the vial. The Narcotic Log for Resident 96's morphine indicated, the last dose was given on 2/5/25 and there were 4.5 ml of morphine left in the vial. LVN 4 retrieved Resident 96's morphine vial from the medication cart and stated there were 9 ml left in the vial. A review of the Narcotic Log for Resident 96's methadone indicated the last dose was given on 2/5/25 and there were 10 ml of methadone left in the vial. RN 3 retrieved Resident 96's methadone vial from the medication cart and stated there were 16 ml left in the vial. During an interview on 2/6/25 at 1:35 p.m. with the Director of Nursing (DON), the DON stated there should be no discrepancies between what is documented in the Narcotic Logs and the controlled medications in the medication carts. During a review of facility's policy and procedure (P&P) titled, Controlled Medications, dated 3/18/18, the P&P indicated, The facility nursing staff and the pharmacy will follow procedure to assure that the controlled drugs are accounted for, and their use readily traceable. 4. During a concurrent interview and record review on 2/5/25 at 10:45 a.m. with RN 3, RN 3 provided the Shift Verification of Controlled Substances sheet (Verification Sheet) for the East Wing of the facility for February 5, 2025. RN 3 stated the Verification Sheet was used by nurses at shift change to document that all doses of controlled medications stored in the medication cart matched the doses documented on the Narcotic Log. RN 3 stated during each shift change, at 6:30 a.m., 2:30 p.m., and at 10:30 p.m., both the outgoing and the incoming nurses signed the Verification Sheet. The Verification Sheet for February 5, 2025, indicated it had already been signed by the outgoing nurse for the shift ending at 2:30 p.m., but was not signed by the incoming nurse. RN 3 stated both nurses had to sign the Verification Sheet at the same time during shift change. During an interview on 2/6/25 at 1:35 p.m. with the DON, the DON stated nurses should not sign the shift verification of controlled substances in advance. During a review of facility's P&P titled, Controlled Medications, dated 3/18/18, the P&P indicated, Controlled drug reconciliation every shift . controlled drug quantities will be verified and reconciled at the change of each nursing shift . at the completion of each nursing shift, the on-coming and off-going nurses will count and reconcile the controlled drugs . each nurse will sign that such count on the Verification of controlled substance sheet as accurate.

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	02/06/2025

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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 44134 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 18) was provided adaptive equipment (specialized tools, devices and modifications designed to assist individuals with disabilities or functional limitations with eating) during meals. This failure had the potential to result in nutritional decline. Findings: During a review of Resident 18's Order Summary Report (OSR), dated 2/5/25, the OSR indicated, Pt [Patient] to have build [sic] up foam utensils with all meals, with an order date of 11/3/23. During a review of Resident 18's Care Plan (CP), (undated), the CP indicated, Resident at risk for Nutritional Decline Due to.Need Adaptive Equipment r/t [related to] lack of coordination.Resident to use utensils with soft build-up handles (brown). During a concurrent observation and interview on 2/5/25 at 12:27 p.m. with Registered Nurse (RN) 2 in Resident 18's room, Resident 18 was eating lunch with regular utensils. RN 2 stated Resident 18 was using regular utensils and would have to check to see if adaptive equipment was needed during meals. During a concurrent interview and record review on 2/5/25 at 12:30 p.m. with RN 2, Resident 18's Physician Order (PO), dated 11/3/23 was reviewed. RN 2 stated the order indicated Resident 18 was to have build up foam utensils with all meals. RN 2 stated Resident 18 should have had build up utensils and it was the responsibility of the kitchen to provide them to residents. During a review of the facility's policy and procedure (P&P) titled, Nutrition Care, dated 2018, the P&P indicated, Adaptive eating devices shall be readily available during meal times for those residents/patients assessed to need them.3. The Department of Food and Nutrition Services is responsible for sanitizing, storing, and assuring that the adaptive devices are provided at each meal.

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	02/06/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47095 Based on observation, interview, and record review, the facility failed to ensure professional standards for food service safety and sanitary kitchen conditions when: 1. Dented canned products were retained in dry storage for use. 2. Dry food storage container lid was not closed and secured per safe storage and guidelines. These failures had the potential to cause foodborne illness (illness caused by the ingestion of contaminated food or beverages) for at-risk vulnerable residents. Findings: 1. During a concurrent observation and interview on 2/3/25 at 8:59 a.m. with Dietary Manager (DM), in the dry food storage room (DFSR), multiple dented 50-ounce tomato soup cans were stored. DM stated the dented tomato soup cans shouldn't be in here, and needed to be removed. DM stated there were nine out of 12 tomato soup cans dented. DM stated the dented tomato soup cans posed a food safety risk. During a concurrent interview and record review on 2/3/25 at 2:16 p.m. with DM, the facility's policy and procedure (P&P) titled, SANITATION AND INFECTION CONTROL SUBJECT: CANNED AND DRY GOODS STORAGE, dated 2018 was reviewed. The P&P indicated, POLICY: all the food and non-food items purchased by the Department of Food and Nutrition services will be stored properly. PROCEDURES. 10. Canned food items should be routinely inspected for damage such as dented. cans. These items should be set aside in a designated area for return to the vendor or disposed of properly. DM stated the P&P was not followed and should have been. DM stated the designated [dented can] place is in my office. 2. During a concurrent observation and interview on 2/3/25 at 9:09 a.m. with DM in the DFSR, the dry lentil beans 22-quart container was open. DM stated the lentil beans container lid should have been closed. DM stated, the open lid could cause food contamination or insects can go in. During a concurrent interview and P&P review on 2/3/25 at 2:19 p.m. with DM, the facility's P&P titled, SANITATION AND INFECTION CONTROL SUBJECT: CANNED AND DRY GOODS STORAGE, dated 2018 was reviewed. The P&P indicated, POLICY: all the food and non-food items purchased by the Department of Food and Nutrition services will be stored properly. PROCEDURES. 9. Metal, plastic containers (with tight fitting lids). will be used. DM stated the kitchen staff were expected to follow policy.

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	02/06/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34510 Based on observation, interview, and record review, the facility failed to implement infection control practices when: 1. Three of three sampled personal laundry cart covers were soiled and discolored. This failure had the potential for contaminating clean linen and spread of infection to residents. 2. One of three sampled clean linen closets had a dark discolored floor with debris. This failure had the potential for contaminating clean linen and spread of infection to residents. 3. Two of two Registered Nurses (RN 1 and RN 3) failed to clean and disinfect glucometers (medical devices used to measure the amount of glucose[sugar] in the blood) according to facility policy and manufacturer's guidelines. after resident use. This failure had the potential to expose residents to bloodborne pathogens (microorganisms [bacteria or virus] in the blood that can cause life threatening disease). Findings: 1. During a concurrent observation and interview on 2/4/25 at 1:58 p.m. in the laundry room with Housekeeping and Laundry Aide ([NAME]), there were three personal laundry carts loaded with residents' clean personal clothes. The laundry carts' mesh covers were soiled and discolored. [NAME] stated, Those covers [personal laundry cart mesh covers] were white and now they are brownish tan. During an interview on 2/4/25 at 2 p.m. with Housekeeping and Laundry Supervisor (HLS), HLS stated the laundry carts' mesh covers needed to be replaced. HLS stated the clean laundry needed protection from dusts during transport. During a review of the facility's policy and procedure (P&P) titled, Handling Linen and Resident's Personal Laundry, dated 5/7/12, the P&P indicated, Purpose: To ensure linen is handled, stored and transported in a safe and sanitary manner to prevent cross contamination and the potential for disease transmission. B. Clean linen from the laundry room shall be delivered in clean covered laundry carts. 2. During a concurrent observation and interview on 2/4/25 at 2:12 p.m. with HLS in the clean linen closet, the clean linen closet floor had dark gray discolorations and debris. HLS stated, It [floor] has not been cleaned in a while. During a review of the facility's P&P titled, Environmental Services Infection Prevention & Control, dated 6/1/17, the P&P indicated, Floors will be cleaned using microfiber floor cleaning products daily using the detergent germicide. 37797 (continued on next page)

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	02/06/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent observation, interview, and record review on 2/4/25 at 3:25 p.m. with RN 1, RN 1 checked the blood sugar level of Resident 18 with a [NAME] True Metrix PRO (brand name) glucometer. After reading the results, RN 1 wiped the glucometer with a Super Sani-Cloth (brand name) Germicidal Disposable Wipe. The glucometer dried in fewer than 10 seconds. RN 1 stated the glucometer was disinfected and ready to be used for the next resident. The label of the Super Sani-Cloth Germicidal Disposable Wipe was reviewed. The label indicated Disinfects in 2 minutes. During an interview on 2/6/25 at 8:18 a.m. with the Infection Preventionist Nurse (IPN), the IPN stated glucometers should be disinfected after each use using Super Sani-Cloth Germicidal Disposable Wipes. The IPN stated staff should keep the glucometer wet with the wipe's solution for at least three minutes to eliminate bloodborne pathogens. The IPN stated failure to follow the three-minute contact time could result in the transmission and infection of residents with bloodborne pathogens. 44134 During an observation on 2/5/25 at 12:19 p.m. in Resident 119's room, RN 3 used a glucometer to check Resident 119's glucose level. After use, RN 3 wiped the glucometer with one alcohol prep pad (a sterile gauze pad that is soaked in alcohol antiseptic[prevents the growth and action of microorganisms]) that measured approximately one inch by one inch. RN 3 cleaned the glucometer for less than 30 seconds. RN 3 then left Resident 119's room, walked into the hallway and placed the glucometer on top of a medication cart. During a concurrent observation and interview on 2/5/25 at 12:21 p.m. in the hallway near Resident 119's room, RN 3 picked up the glucometer that was sitting on top of the medication cart and placed it into the medication carts top drawer. RN 3 stated the glucometer had been cleaned with an alcohol prep pad in Resident 119's room, prior to placing it into the medication cart drawer. RN 3 stated she cleans the glucometers with alcohol prep pads after each use. RN 3 stated the facility policy is to clean the glucometers with alcohol after use. During an interview on 2/6/25 at 8:20 a.m. with IPN, IPN stated glucometers are to be cleaned for three minutes after each use with Sani-Wipes. IPN stated if the glucometers are not properly cleaned there was a risk for transmission-based infection. IPN stated it was not appropriate for staff to clean glucometers with alcohol pads. During a review of the [NAME] True Metrix PRO Glucometer manual, (undated), the manual indicated, Meter should be cleaned and disinfected between patients. To Disinfect: Using fresh wipes, make sure that all outside surfaces of the meter remain wet for 2 minutes . During a review of facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Glucometer, revised 7/15/21, the P&P indicated, Disinfect (after each use) after cleaning the exterior surfaces following the manufacturers' directions using a cloth/wipe with either and [sic] EPA-registered detergent/germicide with a tuberculocidal [kills pathogens] and HBV/HIV [bloodborne pathogen] label claim. Alcohol should not be used unless indicated by manufacturer's label and instructions.

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	02/06/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 34510 Based on interview and record review, the facility failed to ensure nine of nine employees' (Plant and Maintenance [PM], Housekeeper [HSK] 1, Certified Nursing Assistant [CNA] 1, CNA 2, Registered Nurse [RN] 2, Licensed Vocational Nurse [LVN] 1, Nursing Assistant [NA] 1, NA 2, and NA 3) Covid 19 (infectious respiratory illness) vaccination status were tracked and recorded. This failure had the potential to spread Covid-19 to residents, staff, and visitors. Findings: During a review of the facility's Employee Covid-19 Vaccination Log, (undated), the Employee Covid-19 Vaccination Log indicated, the following employees had no record of Covid-19 vaccination status: a) PM, hired on 7/16/24. b) HSK 1, hired on 11/14/24. c) CNA 1, hired on 8/12/24. d) CNA 2, hired on 8/15/24. e) RN 2, hired on 11/7/24. f) LVN 1, hired on 10/10/24. g) NA 1, hired on 1/2/25. h) NA 2, hired on 12/31/24. i) NA 3, hired on 1/2/25. During an interview on 2/5/25 at 9:05 a.m. with Infection Preventionist Nurse (IPN), IPN stated, The recently hired staff who have no Covid-19 vaccine immunization record were not recorded because when they were hired, it [Covid-19 vaccination] was not mandatory to get the Covid-19 vaccine. IPN stated, I don't ask them anymore. During an interview on 2/5/25 at 9:09 a.m. with Scheduler Personnel (SP), SP stated the employees who had no Covid-19 vaccination status record are currently employed. During a review of the facility's policy and procedure (P&P) titled, Mandatory Vaccination & Booster Policy, dated 1/1/22, the P&P indicated, All employees are required to report their vaccination status and to provide proof of vaccination to a member of the infection prevention team or human resources. Employees must provide truthful and accurate information about their Covid-19 vaccination status, and if applicable, their testing results.