STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555517	A. Building B. Wing	10/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kern Valley Healthcare District Dp Snf	6412 Laurel Ave Lake Isabella, CA 93240

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess, recognize, escalate and properly respond to an emergency involving one of seven sampled residents (Resident 7) who experienced a physical change of condition (a significant change in a person's health, caregiver support, or functional status that will not usually resolve without further intervention). This failure resulted in a delay in transferring Resident 7 to the hospital for a higher level of care, resulted in a delay in treatment for a Cerebral Infarction (also known as a stroke, it is when blood flow to the brain is stopped, which can result in slurred speech, movement difficulties to one or both sides of the body, numbness, confusion, headache), and an intracranial hemorrhage (type of stroke that causes bleeding in the head), which resulted in Resident 7's functional decline in mobility, decline in ability to feed self, decline in ability to provide self with oral care, decline in ability to toilet self, decline in ability to shower and/or bathe self, decline in ability to dress upper and lower body, decline in ability to put on footwear, decline in ability to provide self with personal hygiene, and decline in ability to walk.Findings:During a review of Resident 7's MDS Assessment, dated [DATE], under the section titled, Brief Interview for Mental Status (BIMS - an assessment of cognition [how well a person thinks, remembers, and learns] with scores ranging from 0 - 15 with the higher the score the more intact their cognition is), the BIMS score was 15 (cognition intact).During a concurrent observation and interview on [DATE] at 1:21 p.m. with Resident 7 in the resident room, Resident 7 was observed in her wheelchair with her right side of face drooping. Resident 7 stated on the evening (no specific time provided) of [DATE] she started to experience slurred speech and right sided body weakness (change from her normal baseline status). She informed staff (no specific staff identified) that she was having a stroke. Resident 7 stated staff (no specific staff identified) called the Nurse Practitioner (NP - a registered nurse with a graduate degree who provides advanced healthcare, including diagnosing and treating illnesses, ordering and interpreting tests, and prescribing medication) who instructed the staff to place Resident 7 back in bed and just monitor. Resident 7 stated, I had cried and yelled for help telling them I'm having a stroke, and they (no specific staff identified) said okay and put me in bed. I don't think that was right because [NP] said he was not going to do anything about it because I am a DNR (Do not resuscitate - a medical order written by a health care provider which instructs providers not to perform CPR [cardiopulmonary resuscitation- an emergency life-saving procedure that is done when someone's breathing or heartbeat has stopped] if a patient's breathing stops or if the patient's heart stops beating).During an interview on [DATE] at 9:05 a.m. with LVN 2, LVN 2 stated she was assigned to Resident 7 on [DATE] during the night shift ([DATE] 7 p.m. to [DATE] 7 a.m.) when Resident 7 complained of right sided weakness and difficulty speaking. LVN 2 stated Resident 7 was stating she was having a stroke, and the right side of her body was having spasms (painful cramps from the tightening of muscles). LVN 2 stated she observed Resident 7 with difficulty speaking and new onset right sided weakness. LVN 2 stated she called the NP regarding Resident 7's worsening condition and he instructed her to place Resident 7 back in bed and make her comfortable because Resident 7 had these types of issues (stroke) in the past. LVN 2 stated she was told by NP, there was nothing that could be done about Resident 7's change in condition because she had a DNR order. LVN 2 stated, I wish I can [sic] take her [Resident 7] to ED [Emergency Department] but that was his [NP] orders. He [NP] never came to see her after I [LVN 2] called. She [Resident 7] is a DNR, but she was not needing resuscitation, she [Resident 7] was needing advanced level of care and assessment. LVN 2 stated she did not pursue any further action after notifying NP of Resident 7's physical change of condition including not calling the Medical Doctor (MD).During an interview on [DATE] at 2:16 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was assigned to care for Resident 7 on [DATE] during the night shift (CNA shift is from 6:30 p.m. to 7 a.m.). CNA 1 stated at the beginning of her shift (6:30 p.m.) Resident 7 was smiling and happy, and able to move about the facility as well as her room using both legs and left arm in her wheelchair. CNA stated at approximately 9:30 p.m. she heard what sounded like a loud cry for help from Resident 7's room. CNA 1 stated she entered Resident 7's room and noticed immediately Resident 7's right side of face and body were noticeably drooping more than her normal. CNA 1 stated, [Resident 7's] face looked like it was hanging, her mouth was hanging, and she was drooling (not her normal status), CNA 1 stated she immediately notified LVN 2 about Resident 7's condition and LVN 2 called NP. CNA 1 stated she was instructed to place Resident 7 back in bed. CNA 1 stated it took three staff members (not identified) to place Resident 7 back into bed. CNA 1

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. (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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct Medical Doctor (MD) and/or Nurse Practitioner (NP - a registered nurse with a graduate degree who provides advanced healthcare, including diagnosing and treating illnesses, ordering and interpreting tests, and prescribing medication) resident assessments per the facility policy and procedure for seven out of seven residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7). This failure had the potential for residents' medical conditions to change without appropriate interventions by the MD or NP. Findings: 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 9/19/25, under the section titled, Brief Interview for Mental Status (BIMS - an assessment of cognition [how well a person thinks, remembers, and learns] with scores ranging from 0 to 15 with the higher the score the more intact the cognitive status is), the BIMS score was 10 (moderately impaired cognition). During an interview on 10/27/25 at 12:11 p.m. with Resident 1, Resident 1 stated MD or NP had not seen the resident for over a year. During a review of Resident 1's PROGRESS NOTE (PN), the PN indicated NP had documented assessing Resident 1 on 12/31/24 (electronically signed by NP on 1/12/25), 1/31/25 (electronically signed by NP on 3/1/25), 2/27/25 (electronically signed by NP on 3/19/25), 3/28/25 (Electronically signed by NP on 5/12/25), 4/30/25 (electronically signed by NP on 5/13/25), 5/26/25 (electronically signed NP on 6/24/25), 6/4/25 (electronically signed by NP on 7/12/25), 7/23/25 (electronically signed by NP on 8/10/25), and 8/24/25 (electronically signed by NP on 9/22/25). During a review of Resident 2's MDS assessment dated [DATE], under the section titled BIMS, the BIMS score was 15 (cognition intact). During an interview on 10/27/25 at 12:16 p.m. with Resident 2, Resident 2 stated MD or NP had not seen the resident in months (not able to give exact amount of time). During a review of Resident 2's PN, the PN indicated NP had documented assessing Resident 2 on 1/8/25 (electronically signed by NP on 2/24/25), 2/27/25 (electronically signed on 3/6/25), 3/6/25 (electronically signed on 3/6/25), 4/30/25 (electronically signed on 5/3/25), 5/25/25 (electronically signed 5/26/25), 6/19/25 (electronically signed 7/6/25), 7/25/25 (electronically signed on 8/9/25), 8/20/25 (electronically signed on 9/22/25), and 9/21/25 (electronically signed on 10/26/25). During a review of Resident 3's MDS assessment dated [DATE], under the section titled BIMS, the BIMS score was 15. During an interview on 10/27/25 at 12:25 p.m. with Resident 3, Resident 3 stated she has not seen her MD or NP in the facility for over three months. During a review of Resident 3's PN, the PN indicated NP had documented assessing Resident 3 on 12/31/24 (electronically signed by NP on 1/19/25), 1/31/25 (electronically signed by NP on 2/15/25), 2/27/25 (electronically signed by NP on 3/19/25), 4/30/25 (electronically signed by NP on 5/4/25) 5/25/25 (electronically signed by NP on 6/24/25), 6/24/25 (electronically signed NP on 7/8/25), 7/23/25 (electronically signed by NP on 8/9/25), 8/24/25 (electronically signed by NP on 9/17/25), and 9/20/25 (electronically signed by NP on 10/26/25). During a review of Resident 4's MDS assessment dated [DATE], under the section titled BIMS, the BIMS score was 15.During an interview on 10/27/25 at 12:36 p.m. with Resident 4, Resident 4 stated she has been in the facility for two years this coming May (2026). Resident 4 stated she saw an MD when she first arrived to the facility almost two years ago and has not seen the MD or NP in a very long time (could not specify how much time has passed but stated it has been a few months).During a review of Resident 4's PN, the PN indicated NP had documented assessing Resident 4 on 12/31/24 (electronically signed by NP on 1/22/25), on 1/31/25 (electronically signed on 2/15/25), 2/27/25 (electronically signed by NP on 3/19/25), 3/8/25 (electronically signed by NP on 5/12/25), 4/30/25 (electronically signed by NP on 5/13/25), 5/25/25 (electronically signed by NP on 6/30/25), 6/24/25 (electronically signed by NP on 7/12/25), 7/24/25 (electronically signed by NP on 8/28/25), 8/28/25 (electronically signed by NP on 9/17/25), and 9/19/25 (electronically signed by NP on 10/26/25).During a review of Resident 5's MDS assessment dated [DATE], under the section titled BIMS, the BIMS score was 15.During an interview on 10/27/25 at 12:49 p.m. with Resident 5, Resident 5 stated she has seen the NP two or three times since she admitted to the facility (2/2024) and the MD maybe once. Resident 5 stated, I don't think they (NP and MD) come as they should be and they don't follow up.During a review of Resident 5's PN, the PN indicated NP had documented assessing Resident 5 on 12/31/24 (electronically signed by NP on 1/19/25), 1/31/25 (electronically signed by NP on 2/15/25), 2/27/25 (electronically signed by NP on 3/19/25), 3/28/25 (electronically signed by NP on 5/14/25), 4/30/25 (electronically signed by NP 5/4/25), 5/25/25 (electronically signed by NP on 5/26/25)