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	06/12/2025

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. The facility failed to ensure tab alarm orders and informed consents were obtained for two of nine Residents (Resident 45 and Resident 14). 1. Resident 45 had no order and no informed consent for tab alarm. 2. Reisdent 14 had no informed consent for tab alarm. This failure had the potential for staff to be untrained in the proper use of alarms. Findings: During an observation on 06/10/25 at 11:57 a.m. in Resident 45's room, Resident 45 had a tab alarm (safety monitor to prevent falls or wandering) attached from the back of the wheelchair to the back of Resident 45's T-shirt. During a review of Resident 45's Minimum Data Set (MDS-a standardized assessment tool to evaluate residents' health status and functional abilities), dated 3/19/25, the MDS indicated, Restraints and Alarms Resident chair alarm not used. During a concurrent interview and record review on 06/11/25 at 10:56 a.m. with Assistant Director of Nursing (ADON), Resident 45's Orders [undated], were reviewed. The orders indicated there was no order for a tab alarm. ADON stated there is no order for a tab alarm for Resident 45, but there should be one. During a concurrent interview and record review on 06/11/25 at 11:10 a.m. with ADON, Resident 45's Informed Consent Form (ICF), dated 1/23/25 was reviewed. The ICF indicated, Proposed Treatment: Tag transmitter to w/c [wheelchair] Reason for Treatment: Safety/Wandering in wheelchair. Resident's Signature/ Resident's Responsible Party was blank. ADON stated Resident 45's consent for the tab alarm is not signed by Resident 45's representative, and it should be. During a review of Resident 45's Care Plan (CP), dated 11/12/24 the CP indicated, Resident 45 transfers self without assistance. Interventions: bed alarm and tab arm while in W/C [wheelchair]. During an observation on 06/09/25 at 10:36 a.m. in Resident 14's room, Resident 14 was sitting in a wheelchair with a tab alarm attached from the back of the wheelchair to the back of Resident 14's T-shirt. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 14's MDS, dated 3/19/25, the MDS indicated, Restraints and Alarms Resident chair alarm daily. During a review of Resident 14's Orders, dated 9/4/2020, the orders indicated tab alarm while in the chair. During a concurrent interview and record review on 6/11/25 at 2:24 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 14's Medical Record (MR) was reviewed. The MR indicated there was no informed consent for the tab alarm. LVN 1 stated there is no consent for the tab alarm in Resident 14's MR. During a concurrent interview and record review on 6/12/25 at 12:13 p.m. with ADON, Resident 14's MR was reviewed. The MR indicated no care plans for the tab alarm. ADON stated there are no care plans initiated for Resident 14's tab alarm. During an interview on 6/11/25 at 2:44 p.m. with ADON, ADON stated there is no alarm policy or process. During an interview on 6/11/25 at 2:56 p.m. with ADON, ADON stated when a resident has any kind of alarm the requirement is to have an order, create a care plan, obtain informed consent and place the alarm documentation in the resident's MDS.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview, and record review, the facility failed to document changes and monitor for one of two residents (Resident 22 and Resident 7) when: 1. A resident (Resident 22) had an unwitnessed fall. This failure resulted in Resident 22's fall being undocumented. 2. A resident (Resident 7) had a medical condition not monitored. This failure had the potential for Resident 7 to not have his blood sugars monitored. Findings: 1. During a review of Resident 22's admission Record (AR) dated 11/28/23, the AR indicated, Alzheimer's disease (memory loss), fracture of left femur (broken bone), seizures (uncontrolled movements of the body), idiopathic normal pressure hydrocephalus (a condition affecting walking, cognitive, and bladder), impaired normal pressure hydrocephalus, macular degeneration (blurred or no vision), and difficulty in walking. During review of Resident 22's Brief Interview for Mental Status (BIMS), (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgment status of the resident. A score of 13 to 15 cognitively intact, 8-12 moderately impaired and 0-7 severe impairment) dated 3/21/25, the BIMS indicated, a score of 12 impaired. During a concurrent interview and record review on 6/11/25 at 9:04 a.m. with Assistant Director of Nursing (ADON), Resident 22's Nursing Note, dated 6/5/25 was reviewed. The Nursing Note indicated, Resident 22 had an unwitnessed fall on 6/4/25. ADON stated the nurse should have started the fall protocol and document in the care plan. During a review on Resident 22's Care Plan (CP), dated 10/15/24, the CP indicated, Falls: History of falling with left hip fracture with poor balance, unsteady gait, and dx [diagnosis] of severe osteoporosis, use of pain medication, poor vision. Resident at risk for future falls. Observe for changes in condition that may warrant increased assistance and notify the physician prn [as needed] dated 12/10/23. During a review of facility's policy and procedure (P&P) titled, Safety Management, dated 10/09, the P&P indicated, Nursing staff will assess patient/resident on admission and continuing staff using fall assessment guidelines. History for falls prior to or during hospitalization will be documented on care plan. 2. During a concurrent interview and record review on 6/11/25 at 9:09 a.m. with ADON, Resident 7's Comprehensive Care Plan, (CP) dated 11/10/24 was reviewed. The CP indicated, there were no indicators of Identify and prevent hyper/hypoglycemia (low blood sugars and when blood sugars rise above a healthy range) thru next review. ADON stated yes, the care plan should have hypo and hyperglycemic indications. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 7's Order Summary (OS) dated 10/1/24 and 4/5/25 was reviewed. The OS indicated, Insulin Glargine [long-acting medication] Solution 100 unit /ml [millimeter-unit of measurement] inject subcutaneously one time a day for diabetes. Hold for BS [blood sugar] less than 80. Novolin R flex pen injection solution pen injector 100 unit/ml (insulin regular (Human) Inject as per sliding scale if 0-60-0 units, follow protocol notify MD [medical doctor]; 61-150= 0 units, 151-200= 2 units, 201-250= 4 units; 251- 300 units=6 units, 301-350= 8 units; 351- 400= 10 units; 401-999=0 units notify MD for orders. During a review of facility's policy and procedure (P&P) titled, Care Plan Development Process, dated 2/8/16, the P&P indicated, Therefore, acute, temporary problems may be incorporated into the comprehensive plan of care as appropriate.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review the facility failed to ensure they staffed a Registered Nursed (RN) eight hours a day for seven days a week from 9/2024 to 12/2024. This failure had the potential to affect the quality of care of the residents and put the residents at risk for injury. Findings: During a review of the Payroll Staffing Data Report (PBJ) (an electronic system for facilities to submit staffing information) dated 10/1/24 to 12/31/24, the PBJ indicated, no RN hours dated 10/6,10/9,10/13,10/16,10/18, 10/19,10/20,10/23/24,11/3,11/9,11/10,11/17,11/23, 11/24,11/28,11/29,11/30/24, 12/1,12/7,12/8,12/13,12/14, 12/15,12/16,12/21,12/22, 12/24,12/25,12/26,12/27,12/28,12/29/24. During a concurrent interview and record review on 6/12/25 at 10:50 a.m. with Staffing Coordinator (SC) the facility's Staffing Log dated 9/2024 to 12/2024 was reviewed. The Staffing log indicated on the following dates there was no RN for the regulated eight hours per day: On 9/6/24, 6.28 RN hours worked. On 9/7/24, 0 RN hours worked. On 9/15/24, 3.68 RN hours worked. On 9/16/24, 0 RN hours worked. On 9/18/24, 7.97 RN hours worked. On 9/22/24, 0, RN hours worked. On 10/6/24,0 RN hours worked. On 10/7/24,7.92 RN hours worked. On 10/12/24,7.56 RN hours worked. On 10/13/24,0 RN hours worked. On 10/15/24,7.32 RN hours worked. On 10/16/24,0 RN hours worked. On 10/19/24,0 RN hours worked. On 10/20/24,0 RN hours worked. On 10/27/24,5.92 RN hours worked. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/3/24,0 RN hours worked. On 11/4/24, blank RN hours worked. On 11/9/24,0 RN hours worked. On 11/10/24,0 RN hours worked. On 11/15/24,3.97 RN hours worked. On 11/16/24,2.5 RN hours worked. On 11/17/24,0 RN hours worked. On 11/19/24,6.68 RN hours worked. On 11/22/24,6.03 RN hours worked. On 11/23/24,0 RN hours worked. On 11/24/24,0 RN hours worked. On 11/27/24,7.13 RN hours worked. On 11/28/24,0 RN hours worked. On 11/29/24,0 RN hours worked. On 11/30/ 24,0 RN hours worked. On 12/1/24, 0 RN hours worked. On 12/4/24, 5.33 RN hours worked. On 12/6/24, 7.97 RN hours worked. On 12/7/24, 0 RN hours worked. On 12/8, 0 RN hours worked. On 12/12/24, 4.8 RN hours worked. On 12/14/24, 0 RN hours worked. On 12/15/24, 0 RN hours worked. On 12/16/24, 0 RN hours worked. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/19/24, 6.55 RN hours worked. On 12/21/24, 0 RN hours worked. On 12/22/24, 0 RN hours worked. On 12/24/24, 0 RN hours worked. On 12/25/24, 0 RN hours worked. On 12/26/24, 0 RN hours worked. On 12/28/24, 0 RN hours worked. On 12/29/24, 0 RN hours worked. On 12/30/24, 7.57 RN hours worked. SC stated we are not getting staff. SC stated when we get applications, a requirement is they have previous skilled nursing facility experience. SC stated I reach out to registries when we do not have any applications.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on observation, interview, and record review the facility failed to ensure dental needs were met, and followed up for one of two sampled residents (Resident 47). This failure resulted in Resident 47 not recieving dentures, feeling embarrassed, and refusing to socialize with other residents. Findings: During a review of Resident 47's admission Record (AR), the AR indicated, admission date 11/7/24. Diagnosis Information: depression [is a mood disorder that causes a constant feeling of sadness and loss of interest in daily activities]. During a review of Resident 47's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgment status of the resident. Scores range from 0 to 15, with higher scores indicating better cognitive function. A score of 13-15 suggests intact cognition, 8-12 suggests moderate impairment, and 0-7 suggests severe impairment.), dated 3/19/25, the BIMS indicated Resident 47's score is 14. During a concurrent observation and interview on 6/09/25 at 10:08 a.m. with Resident 47, in Resident 47's room, Resident 47 had no teeth and it was difficult to understand what she was saying. Resident 47 stated, she had dentures before coming to the facility, but she must have lost them because she no longer has her dentures. Resident 47 stated she has asked the facility to help get her dentures so she can participate in activities; however, she is still waiting on new dentures. During an interview on 6/09/25 at 12:25 p.m. with Resident 47, Resident 47 stated she doesn't feel right participating in activities because she feels as if other residents are judging her because she does not have teeth. Resident 47 stated she feels embarrassed but would like to socialize with others but cannot because she has no teeth. During an interview on 6/11/25 at 8:46 a.m. with Activities Assistant (AA), AA stated Resident 47 has stated she will not participate in activities due to not having dentures. AA stated because Resident 47 will not join activities AA is only completing room visits twice a week at this time. AA stated not participating in activities and staying in her room can cause Resident 47 to become more depressed. AA stated Resident 47 used to come out to activities upon admission and had great socialization skills but no longer wants to come out of her room. AA stated she has not told anyone in management that Resident 47 is embarrassed to come to activities due to her not having any dentures. During a concurrent interview and record review on 6/11/25 at 11:18 a.m. with Assistant Director of Nursing (ADON), Resident 47's Medical Record (MR) was reviewed. The MR indicated upon admission a dental appointment was made for Resident 47 on 12/11/24. Resident 47 was in too much pain to go to this appointment, and it was rescheduled for 1/7/2025. On 1/7/25 Resident 47 was transported to the dental appointment and had x-rays (images taken of the inside of your mouth) completed for dentures. On 4/1/25 Resident 47 had her annual dental exam. ADON stated there was no follow up on Residents 47's dentures until 5/8/25 when Social Services called the dental office and requested an update, but no update was given. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 11:37 a.m. with Social Services Designee (SSD), SSD stated the reason there has not been a follow up for Resident 47's dentures is because the dental office is still waiting on an authorization from the insurance company which can take several months to a year to obtain. SSD stated this happened to another resident and she had to call the medical ombudsman to obtain the authorization; however, she has not done that for Resident 47. SSD stated she tries to only follow up with the dental office when she must call for other residents because it is too hard to get someone to answer the phone. SSD stated she does not document any follow up conversations into the resident's MR. During an interview on 6/11/25 at 11:43 a.m. with ADON, ADON stated SSD should document all follow up calls in the resident's MR. During a review of resident 47's Social Services Note (SSN), dated 11/7/24 the SSN indicated Resident has dentures, but they are not at facility upon admission, son to bring them at later time period resident is interested in a dental exam and she stated that her dentures hurt and don't fit right. During a review of Resident 47's Care Plan (CP), dated 11/8/24, the CP indicated Resident states, I have dentures at home but they hurt and don't fit.Interventions Coordinate arrangements for dental care. During a review of Resident 47's Activity Participation Note (APN), dated 1/4/2025, the APN indicated Had 1-1 [one-to-one] visit with resident, I asked resident if she was going to join activities, resident said not until she gets her teeth and glasses, resident is uncomfortable to be out in activities without those two items. Resident mentioned how the activities sound fun. During a review of Resident 47's APN, dated 1/26/25, the APN indicated, 1-1 room visit, resident lying in bed, I asked resident when she was going to come to activities, resident said once she gets her teeth and glasses. During a review of Resident 47's SSN, dated 2/27/25, the SSN indicated, MSW [Mental Social Worker] met with resident. resident reported she was hoping to go home with her son one day but not at this time because she would like to get her dentures. During a review of Resident 47's Psychiatry Note (PN), dated 4/24/25, the PN indicated, . she reports being moody today and frustrated she's supposed to get false teeth and it's not getting done . During a review of Resident 47's APN, dated 5/31/25, the APN indicated visited with resident, resident lying in bed, I asked resident about coming to activities, resident says not until she gets her dentures. During a review of the facility's policy and procedure (P&P) titled, Dental Services, dated 2/27/12, the P&P indicated Policy: The Skilled Nursing Facility staff will ensure that the dental care needs of its residents are met annually and as needed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to label and store food in a sanitary manner when: 1. Food items were not closed and sealed appropriately in one of one dry storage room. 2. Food items did not have a received by date label in one of one dry storage room. These failures had the potential for Residents eating in the facility to be at risk of acquiring a foodborne illness. Findings: 1. During a concurrent observation and interview on 6/9/25 at 9:52 a.m. with [NAME] 1 in the kitchen's dry storage room, one bag of powdered Cocoa was on the shelf. The bag of Cocoa was not closed or sealed properly, it was open and exposed to room air. [NAME] 1 stated the bag should have been closed and sealed when it was opened. 2. During a concurrent observation and interview on 6/9/25 at 9:57 a.m. with [NAME] 1 in the kitchen's dry storage room, five bottles of [NAME] Brand Chocolate syrup were on the shelf of the dry storage room. All five bottles did not have a received by date. [NAME] 1 stated all food items must have a received by date label on them. During a concurrent observation and interview on 6/9/25 at 10:03 a.m. with [NAME] 1 in the kitchen's dry storage room, 11 cans of Star Kiss tuna were on the shelf of the dry storage room. All 11 cans of tuna did not have a received by date. [NAME] 1 stated all food items must have a received by date label on them. During a review of the facility's policy and procedure (P&P) titled, Food Storage, Labeling & Dating undated, the P&P indicated, It is the policy of Nutrition Services to wrap, cover, label, date, and store all foods in a safe, appropriate manner. To prevent foodborne illness. On each package, either write the expiration date, when item was received.