

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555517	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2026
NAME OF PROVIDER OR SUPPLIER Kern Valley Healthcare District Dp Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>Based on interview and record review the facility failed to follow its policies and procedures (P&P) titled, Staffing, Sufficient and Competent Nursing, for all residents when a Registered Nurse (RN) was not present in the facility for eight working hours. This failure had the potential for residents needs to go unmet. Findings: During a concurrent interview and record review on 4/22/26 at 10:59 a.m. with Director of Nursing (DON), the facility's Total Skilled Nursing Hours (TSNH), dated October 2025 and December 2025 was reviewed. The following dates indicated: On 10/26/25 Census 52 residents, and 0 RN hours. On 10/30/25 Census 52 residents, and 0 RN hours. On 12/29/25 Census 55 residents, and 0 RN hours. On 12/30/25 Census 55 residents, and 0 RN hours. DON stated the facility did not have a RN covering the floor on those dates. During an interview on 4/22/26 at 11:10 a.m. with Assistant Director of Nursing (ADON), ADON stated in October they did not have a RN on 10/26/25 or 10/30/25. During a review of the facility's P&P titled, Staffing, Sufficient and Competent Nursing, dated 7/28/25, the P&P indicated, A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) day a week.</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview and record review, the facility failed to implement effective infection control practices when: Facility staff did not provide hand hygiene to three of five sampled residents (Resident 26, Resident 30, and Resident 15). This failure had the potential to spread infection to residents. Housekeeping staff did not follow Enhanced Barrier Precautions (EBP - gown and gloves are used during care of residents with indwelling medical devices and open wounds, to prevent infection) for one of one sampled resident (Resident 6) when cleaning Resident 6's room. This failure had the potential to result in Resident 6 developing an infection. Findings:</p> <p>1. During an observation on 4/20/26 at 12:26 p.m. with Certified Nursing Assistant (CNA) 3 in Resident 26's room, CNA 3, delivered a lunch tray to Resident 26.</p> <p>During an observation on 4/20/26 at 12: 29 p.m. with CNA 4, in Resident 30's room, CNA 4 delivered and set up Resident 30 's lunch tray by cutting up meat on lunch plate.</p> <p>During an observation and interview on 4/20/26 at 12:36 p.m. with Resident 30 in Resident 30's room, Resident 30 had a lunch tray in front of him and was eating. Resident 30 stated he did not get anything to clean his hands prior to getting his lunch tray.</p> <p>During an observation and interview on 4/20/26 at 12:39 p.m. with Resided 26 in Resident 26's room, Resident 26 had a lunch tray she was using a knife and fork. Resident 26 stated the staff did not give him something to clean his hands before lunch today.</p> <p>During an interview on 4/20/26 at 12:45 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated the process was to provide hand hygiene to the residents prior to the meal.</p> <p>During an interview on 4/20/26 at 12:47 p.m. with Registered Nurse (RN) 1, RN 1 stated the staff were to provide hand hygiene to residents prior to meals.</p> <p>During a concurrent observation and interview on 4/20/26 at 12:50 p.m. with Resident 15, in Resident 15's room. Resident 15 was eating her chocolate pudding with her fingers. Resident 15 was asked if the staff had offered her hand hygiene. Resident 15 stated they did not.</p> <p>During a concurrent observation and interview on 4/20/26 at 12:54 p.m. with CNA 3, in Resident 15's room. CNA 3 was seen giving Resident 15 her lunch tray. CNA 3 was asked if she had provided or offered Resident 15 hand hygiene. CNA 3 stated she did not and she should have.</p> <p>During a review of Resident 15's Brief Interview for Mental Status (BIMS, a screening tool used in long term care to evaluate cognitive function.13-15 points: cognitively intact; 8-12 points: moderate cognitive impairment; 0-7 points: severe cognitive impairment), dated 4/3/26, the BIMS score was 4.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Infection Control-Resident Care Hand Hygiene by Residents, dated 2016, the P&P indicated, Residents are informed and encouraged to perform hand hygiene to prevent transmission of potentially infectious organisms to others.In the case of the non-ambulatory resident, facility staff will assure the resident has access to methods of performing hand hygiene.</p> <p>2. During an observation on 4/22/26 at 9:49 a.m. outside of Resident 6's room, a sign on the wall (continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>indicated Resident 6 was on EBP. Housekeeper (HK) 1 entered Resident 6's room wearing only gloves and cleaned Resident 6's overbed table, top of dresser, handles of drawers, and shutters covering the window.</p> <p>During a concurrent observation and interview on 4/22/26 at 9:56 a.m. with Infection Preventionist (IP), outside of Resident 6's room, HK 1 was mopping the floor wearing only gloves. IP stated Resident 6 was on EBP due to having a urinary catheter (tube inserted into the bladder to drain urine). IP stated HK 1 needed to wear a gown in addition to gloves, while cleaning Resident 6's room.</p> <p>During an interview on 4/22/26 at 9:58 a.m. with HK 1, HK 1 stated the EBP sign indicated that she was to wear a gown and gloves when entering the room, but was not sure which resident was on EBP or why. HK 1 stated she did not wear a gown while cleaning Resident 6's room.</p> <p>During a review of the facility's P&P titled, Infection Control & Transmission-based Precautions, dated 6/13/24, the P&P indicated, C. Enhanced Barrier Precaution is used for residents with medical devices and chronic wounds. 6 moments of care: cleaning the environment. Enhanced Barrier Precautions include: . a. Personal Protective Equipment (PPE) [gloves and gown] are made available. 1) All personnel and visitors are to make use of the PPE necessary for protection before going into the room when the anticipated 6 moments of care are provided. 3) Gloves: Must be worn by staff upon entering the room and removed upon leaving when providing 6 moments of care is anticipated. 4) Gowns: Will be worn when providing 6 moments of care and anytime there is an anticipation of contamination from the resident and or the environment.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on observation, interview, and record review, the facility failed to follow its Policy and Procedure (P&P) titled, Medication Storage, for one of one medication cart when Licensed Vocational Nurse (LVN) 1, left the medication cart unlocked in the hallway. This failure had the potential for accidental ingestion of medication by a wondering resident. Findings: During an observation on 4/21/26 at 11:39 a.m. with LVN 1 in the hallway during medication pass, there was unattended blood sugar supplies (including lancets [small needle], diabetic test strips, testing solutions and glucometer) on top of a medication cart that was left unlocked. During an observation on 4/21/26 at 11:51 a.m. with LVN 1 in hallway outside Resident 6's room during medication pass. there were unattended blood sugar supplies and the medication cart was left unlocked. During an interview on 4/21/26 at 11:53 a.m. with LVN 1, LVN 1 stated normally when he walked away, he would lock the medication cart. During an interview on 4/21/26 at 11:55 a.m. with LVN 2, LVN 2 stated yes, she did see LVN 1 did not lock the medication cart twice when he walked away. LVN 2 stated yes, the blood sugar supplies needed to be locked on top of the cart. During a review of the facility's P&P titled, Medication Storage, dated 5/26/15, the P&P indicated, Medications shall be locked and attended by persons with authorized access.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview and record review, the facility failed to ensure two of two sampled housekeeping carts (Cart 1 and Cart 2) were secured and cleaning chemicals were not accessible by residents. These failures had the potential to result in residents accessing the cleaning chemicals causing injury or death. Findings: During a concurrent observation and interview on 4/22/26 at 9:43 a.m. with Housekeeper (HK) 1 by Cart 1, Cart 1 had an open bucket on the outside of the cart that was half full of clear liquid. HK 1 used a measuring container to dip the liquid from the bucket and poured it into the mop handle, then placed the container back into the bucket. A small bucket was on top of the cart half full of clear liquid. A pocket on the side of the cart contained two containers, one labeled Super Sani Cloth [cleaning chemical], and one labeled Sani Cloth Bleach [cleaning chemical]. HK 1 stated the smaller bucket contained a cleaning chemical used to wipe down the resident rooms. During a concurrent observation and interview on 4/22/26 at 10:03 a.m. with HK 2 by Cart 2, Cart 2 had an open bucket on the outside of the cart that was half full of clear liquid, with mop heads a measuring container. A small bucket on top of the cart contained clear liquid. A pocket on the side of the cart contained two containers, one labeled Super Sani Cloth, and one labeled Sani Cloth Bleach. HK 2 stated the mop bucket and small bucket (on top of cart) contained microkill 3 [cleaning chemical]. HK 2 stated the container in the mop bucket was used to pour cleaning chemical into the mop handle. HK 2 stated the cart was not to be left unattended while in the facility because there were some confused residents who would take things off the cart. HK 2 stated she was unable to stay with the cart at all times, while she was in the resident rooms cleaning, the cart was left unattended. During an interview on 4/23/26 at 12:04 p.m. with Director of Nursing (DON), DON stated housekeeping staff were to keep cleaning chemicals locked and secured at all times while in the facility due to confused residents who liked to wander the hallways. DON stated the confused residents could pick something up and be injured. During a review of the facility's policy and procedure (P&P) titled, Cleaning Skilled Nursing Resident Room, dated 3/2/11, the P&P indicated, E. Housekeeping personnel will keep the cleaning cart in view at all times in the Skilled Nursing Unit. F. No dangerous items will be kept on the cart.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>During an observation, interview, and record review, the facility failed to ensure one of two cooks (Cook 2) followed the Hair and beard Restraint policy and procedures (P&P), when [NAME] 2 did not have a beard cover. This failure had the potential for food contamination. Findings: During an observation on 4/21/26 at 10:45 a.m. in the kitchen, [NAME] 2 had a full beard on his face. [NAME] 2 was cutting up strawberries and was not wearing a beard cover. During an interview on 4/21/26 at 10:47 a.m. with [NAME] 2, [NAME] 2 stated he should use a beard cover while in the kitchen. During an interview on 4/21/26 at 10:51 a.m. with Certified Dietary Manager (CDM) in the kitchen, CDM stated she did not know why [NAME] 2 was not wearing a beard cover and stated he should have been. During a review of the facility's P&P titled, Hair and [NAME] Restraint' dated 2020, the P&P indicated, Hair and beard restraints are designed and worn to effectively keep hair from contacting food, clean equipment and utensils. Staff entering and working in the kitchen must wear a hair and beard restraint.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, interview, and record review, the facility failed to ensure physician orders (PO) to monitor oxygen saturation (O2 Sat- a measurement of how much oxygen your blood is carrying as a percentage of the maximum it could carry) was followed for one of eight sampled residents (Resident 1). This failure had the potential for Resident 1 not to receive the appropriate oxygenation that is required to maintain the parameters the physician ordered. Findings:During an observation on 4/20/26 at 10:50 a.m. in Resident 1's room. Resident 1 was not receiving oxygen (a colorless and odorless gas that is essential for life) while lying in her bed.During a concurrent observation and interview on 4/20/26 at 3:11 p.m. with Resident 1 in Resident 1's room, an oxygen concentrator (a medical device that delivers oxygen in short bursts upon inhalation) was seen in Resident 1's room. Resident 1 was not using her nasal cannula (a flexible tube put in the nostrils to deliver supplemental oxygen to a patient). Resident 1 stated she did not need the oxygen machine in her room.During a concurrent observation and interview on 4/20/26 at 3:19 p.m. with Registered Nurse (RN) 9 in Resident 1's room, Resident 1 was not using her nasal cannula. RN 9 stated Resident 1's PO for oxygen is PRN (as needed) and at medication pass they check her O2 Sat's.During a review of Resident 1's Brief Interview for Mental Status (BIMS- a screening tool used in long term care to evaluate cognitive function.13-15 points: cognitively intact; 8-12 points: moderate cognitive impairment; 0-7 points: severe cognitive impairment), dated 3/3/26, the BIMS score was 9.During a concurrent interview and record review on 4/22/26 at 1:45 p.m. with Assistant Director of Nurses (ADON), Resident 1's Order Summary (OS), dated 2/24/26 was reviewed. The OS indicated, Verify O2 saturation is at or above 92% [percent] if outside parameters notify RN to titrate as indicated to achieve O2 saturation at or above 92% two times a day.During a concurrent interview and record review on 4/22/26 at 1:49 p.m. with ADON, Resident 1's Medication Administration Record (MAR), O2 Sat results dated April 2026, were as follows:4/21/26 O2 Sat was 91%, ADON stated there was no documentation that an RN was notified and no O2 was administered to Resident 1.4/18/26 O2 Sat was 90%, ADON stated there was no documentation that an RN was notified and no O2 was administered.4/17/26 O2 Sat was 90%, ADON stated there was no documentation that an RN was notified and no O2 was administered.4/16/26 O2 Sat was 91%, ADON stated there was no documentation that an RN was notified and no O2 was administered.4/15/26 O2 Sat was 83%, ADON stated there was no documentation that an RN was notified and no O2 was administered.4/4/26 O2 Sat was 89%, ADON stated there was no documentation that an RN was notified and no O2 was administered.During an interview on 4/22/26 at 2:09 p.m. with ADON, ADON stated the Licensed Vocational Nurses (LVN's) did not follow the PO for O2 management and stated they should have. During a review of the facility's policy and procedure (P&P) titled, Oxygen Delivery, dated 2014, the P&P indicated, Oxygen therapy shall be initiated with an appropriate physician order.Acknowledge order. Check the physician order noting the indications, contraindications, and hazards of the type of therapy ordered.</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P), titled Foods Brought in by Family or Visitors, when a designated refrigerator was not provided for resident's food that is brought in by family. This failure had the potential to place residents at risk of foodborne illness due to unmonitored food brought in by the family and could limit food choices and options for residents. Findings: During an interview on 4/23/26 at 8:42 a.m. in the staff breakroom with Certified Nursing Assistant (CNA) 1, CNA 1 was asked if residents were allowed or able to have food brought in to the facility from their family. CNA 1 stated she was new and stated she believed residents were able to receive food from visitors or family. CNA 1 stated she was not aware of the process or where to store the residents food brought in from family. During an interview on 4/23/26 at 8:46 a.m. in the activities room with CNA 2, CNA 2 was asked if residents were allowed or able to have food brought in to the facility from their family. CNA 2 stated she believed residents were able to keep food bought in from family in the activities refrigerator. CNA 2 stated I guess I don't know where the residents would put their food. During an interview on 4/23/26 at 8:55 a.m. with Activities Assistant (AA), AA stated she was not aware that the residents food could be stored in the activities refrigerator. During an interview on 04/23/2026 8:57 a.m. with the Director of Nurses (DON), DON was asked if the facility had a refrigerator where the residents may store food brought in from family or visitors. DON stated we do not have a designated refrigerator for the residents food. During a concurrent interview and record review on 04/23/2026 8:58 a.m. with DON, P&P titled Food Brought in by Family or Visitors dated 4/10/2026 was reviewed. The P&P indicated Storage of Outside Food: Perishable food brought in from outside sources may be stored in designated unit refrigerators. DON stated they no longer have a designated refrigerator for food brought into for the residents from the outside.</p>		

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<p>F 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have policies on smoking.</p> <p>Based on observation, interview and record review, the facility failed to develop and implement a policy and procedure (P&P) for smoking for one of one resident (Resident 45). This failure had the potential to result in Resident 45 being unsafe while smoking and injury of Resident 45 and other residents. Findings: During an observation on 4/21/26 at 11:06 a.m. in the courtyard outside the door of the activities room, Resident 45 used a lighter to light a cigarette with procedure mask pulled down around her chin (still hooked over each ear). No facility staff was present, no ashtrays were within reach and there was a no smoking sign on the door to the activities room. During an observation on 4/21/26 at 11:20 am in the courtyard outside the door of the activities room, Resident 45 extinguished her cigarette on the side of a cup hanging on the side of her wheelchair, and placed the cigarette butt in the cup. Resident 45 then lit another cigarette, while her procedure mask was still pulled down around her chin (still hooked over each ear). There was no facility staff present. During an observation on 4/23/26 at 9:25 a.m. Resident 45 was lying in bed, with eyes closed and did not respond when greeted. Resident 45's wheelchair had a cup attached to the side with a cigarette case in the cup. The cigarette case contained a lighter. During a concurrent observation and interview on 4/23/26 at 9:29 a.m. with Certified Nursing Assistant (CNA) 5, in Resident 45's room, a lighter was in a cigarette case on Resident 45's wheelchair. CNA 5 stated Resident 45 was not allowed to have the lighter and was to give the lighter back to staff when she finished smoking each time. During an interview on 4/23/26 at 9:34 a.m. with Registered Nurse (RN) 1, RN 1 stated Resident 45 does not return her lighter sometimes and staff have to go look for it. RN 1 stated Resident 45 sometimes uses the cup on the side of her wheelchair to dispose of cigarette butts, but needed to use the facility provided ashtrays. RN 1 stated the facility had multiple confused residents who liked to wander and were at risk of injury due to having access to the lighter. During an interview on 4/23/26 at 12:15 p.m. with Director of Nursing (DON), DON stated there was no policy outlining the expectations for those residents who are allowed to smoke. DON stated Resident 45 was expected to smoke in the designated smoking area, use the facility provided ashtrays and return the lighter to the charge nurse to be locked up until needed again.</p>