STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555766	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Medical Center	465 W Putnam Ave Porterville, CA 93257

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40516 Based on interview and record review, the facility failed to ensure two of 30 sampled residents (Resident 2 and Resident 7) were represented with an individual or entity other than the facility's Interdisciplinary Team (IDT- group of health care professionals including doctors, nurses, pharmacists, social workers, and dieticians who coordinate care). This failure resulted in Resident 2's and Resident 7's right to have a surrogate decision-maker not being honored. Findings: During a review of Resident 2's Facesheet, undated, the Facesheet indicated the Next of Kin section was blank. The Person to Notify indicated, Team, Interdisciplinary SNF [skilled nursing facility] . will call [facility's medical director]. During a review of Resident 7's Facesheet, undated, the Facesheet indicated the Next of Kin section was blank. The Person to Notify indicated, Team, Interdisciplinary SNF . will call [facility's medical director]. During a concurrent interview and record review on [DATE] 8:48 a.m. with Admin/DON, Resident 2's Facesheet, undated was reviewed. Admin/DON stated the Ombudsman (representative who assists residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences) no longer comes to care planning sessions. Admin/DON stated the IDT is Resident 2's only source of advocacy. During an interview on [DATE] 3:24 p.m. with Admin/DON, Admin/DON stated Resident 2 and Resident 7 have no resident representatives and were both represented by the facility's IDT. During an interview on [DATE] at 9:14 a.m. with Social Services (SS), SS stated Resident 2 has no family or conservator. SS stated IDT team manages Resident 2's care. SS stated a state agency for aging is notified if consents are needed for invasive procedures but not for vaccinations. (continued on next page)

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
	555766	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Medical Center	465 W Putnam Ave Porterville, CA 93257

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 4:15 p.m. with SS, Resident 2's History and Physical (H&P), undated was reviewed. The H&P indicated Resident 2 was in a persistent vegetative state [person is awake but is showing no signs of awareness] for more than [AGE] years. A Social Services Note dated [DATE] indicated, SS received phone call from Ombudsman [name of ombudsman] to inform us she will no longer be attending IDT meetings due to recommendation made by state ombudsman . Resident [2] currently is represented by IDT as she [sic] does not have family involved to assist with decision making or care. SS to reach out to [public conservatorship agency] for guidance on who will continue to represent resident. A Social Services Note dated [DATE] indicated SS spoke with an individual at a public conservatorship agency but no conservatorship was obtained and Resident 2 will continue to [be] represented by IDT for decision making. During a review of Resident 7's H&P, dated [DATE], the H&P indicated, PVS [persistent vegetative state] no cognitive ability [lacks knowledge and reasoning skills]. A Social Services Note dated [DATE] indicated, SS received phone call from Ombudsman [name of ombudsman] to inform us she will no longer be attending IDT meetings due to recommendation made by state ombudsman . Resident [7] currently is represented by IDT as she does not have family involved to assist with decision making or care. SS to reach out to [public conservatorship agency] for guidance on who will continue to represent resident. A Social Services Note dated [DATE] indicated SS spoke with an individual at a public conservatorship agency but no conservatorship was obtained and Resident 7 will continue to [be] represented by IDT for decision making. During a review of the facility's policy and procedure (P&P) titled, Surrogate Decision Maker, Selection Of, (undated), the P&P indicated, The following procedures will be followed for selecting a surrogate [substitute] decision maker when a patient lacks decision-making capacity and lacks a written advance directive for health care or a court appointed conservator [when a judge appoints another person to act or make decisions for the person who needs help] . If the patient has not appointed a surrogate or agent through a valid written or oral directive and if there is no court appointed conservator for health care decision making; or if the designated surrogate, agent [sic] or conservator is not reasonably available, it may be necessary to rely upon the consent given be a relative to make health care decisions on behalf of the patient . If the patient's relatives cannot agree as to who shall be the surrogate decision maker for the patient, then a multi-disciplinary team to include an attending physician, nurse familiar with the patient, social worker familiar with the patient, and a representative from Risk Management will appoint a surrogate. During a review of All Facilities Letter (AFL- letter from state health care agencies to health facilities that are licensed or certified by the state) ,d+[DATE] indicated, Effective [DATE], the [state's] Department of Aging's . [and] Long-Term Care Patient Representative Program (LTCPRP) is operational. The Office of the Long-Term Care Patient Representative (OLTCPR) provides public patient representatives to participate in the IDT process for residents who require a medical intervention that requires informed consent in the absence of a conservator, family member, friend, or legal surrogate decision maker.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555766	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Medical Center	465 W Putnam Ave Porterville, CA 93257

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 47153 Based on observation, interview, and record review, the facility failed to re-evaluate the need for a left-hand mitten (physical restraint used to prevent a person from scratching or pulling at life sustaining equipment) after 90 days per physician's order for one of four sampled residents (Resident 14). This failure had the potential to result in Resident 14 being physically restrained without a physician's authorization. Findings: During an observation on 3/25/24 at 9:42 a.m. in Resident 14's room, there was a hand mitten restraint on the over bed table. During a concurrent interview and record review on 3/25/24 at 2:46 p.m. with Regulatory Registered Nurse (RRN), Resident 14's Physician's Order (PO), dated 12/12/23 was reviewed. The PO indicated, Left hand mitten to prevent from pulling at life sustaining tubes x 90 days, re-eval [re-evaluate]. RRN stated the order for restraints was out of compliance and should have been renewed on 3/12/24. During a concurrent interview and record review on 3/27/24 at 3:46 p.m. with Administrator/Director of Nursing (Admin/DON), Admin/DON stated there is no current physician's order for the left-hand mitten restraint since the charge nurse did not re-evaluate the need for restraint after 90 days per physicians' order. During a review of the facility's policy and procedure (P&P) titled, Restraint Use -Non-Violent, Non Self-Destructive (NVNSD) And Emergency-Violent Self Destructive (VSD), (undated), the P&P indicated, Orders: Restraint will be initiated or continued at the order of the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555766	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Medical Center	465 W Putnam Ave Porterville, CA 93257

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47153 Based on interview and record review, the facility failed to ensure the Crash Cart (emergency cart used to transport and store emergency medications and supplies) used for 30 of 30 sampled residents, was inspected daily. This failure had the potential to result in necessary supplies and medications to be unavailable in an emergency. Findings: During a concurrent interview and record review on [DATE] at 11:37 a.m. with Registered Nurse (RN) 1, the Crash Cart Integrity Check List (CCICL), dated [DATE] through [DATE] were reviewed. The CCICL was not completed on the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. RN 1 stated the crash cart is supposed to be checked every night shift. RN 1 stated, If it's blank, it means it wasn't checked. RN 1 stated the cart needed to be checked because the crash cart supplies and medication might not be functioning and available if it is needed in an emergency. RN 1 stated it should have been checked and CCICL should have been completed. During a review of the facility's policy and procedure (P&P) titled, Crash Carts-Exchanging, Restocking, Security And Verification, (undated) the P&P indicated, Daily Inspection 1. The nurse will assure that: a. The defibrillator [device used in an emergency that applies an electric charge or current to the heart to restore a normal heartbeat] is plugged into the RED electrical outlet and charged. b. Test the defibrillator daily . The initials of the staff nurse performing the check will document that this is completed. 2. Check the contents on top of the crash carts, assuring none of the supplies are compromised or expired. 3. Check the oxygen cylinder for adequate content . Make sure the contents of the Crash Cart are secure by verifying tamper-evident seals are locked and that the lock number corresponds to the number recorded on the log. If the lock is broken, the cart is NOT to be used . Sign the Crash Cart Integrity Check List that is attached to the Crash Cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555766	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Medical Center	465 W Putnam Ave Porterville, CA 93257

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 47444 Based on observation, interview, and record review, the facility failed to ensure the head of bed was raised at least 35 degrees while receiving gastrostomy tube (g-tube - tube inserted directly into the stomach through the abdominal wall, for administration of nutrition and medication) feedings for one of eight sampled residents (Resident 22). This failure had the potential for aspiration (inhaling into lungs) of stomach contents and risk for developing a respiratory infection. Findings: During an observation on 3/25/24 at 9:48 a.m. in Resident 22's room, Resident 22's head of bed was in a 25 degree position while g-tube feeding was being administered via g-tube pump at bedside. During a concurrent observation and interview on 3/25/24 at 9:54 a.m. with Licensed Vocational Nurse (LVN) 3, in Resident 22's room, Resident 22's head of bed was in a 25 degree position. LVN 3 stated Resident 22's head of bed was at 25 degrees and should be at least 35 degrees while the tube feeding is running to decrease the risk of aspiration. During a review of Resident 22's Physician's Order (PO), dated 8/30/23, the PO indicated, Gastrostomy Tube Management Routine.Instructions. Elevate HOB [Head of Bed] 30-35 degrees during feeding. During a review of the facility's policy and procedure (P&P) titled, Administration of Formula via Feeding Tube Gravity, Bolus, Pump, (undated), the P&P indicated, B. Enteral [delivery of nutrients directly into the stomach] Feeding . 5. Elevate head of bed at a 35 - 45 degree angle during the feeding and for at least one hour after feeding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555766	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Medical Center	465 W Putnam Ave Porterville, CA 93257

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 - Some	Provide safe and appropriate respiratory care for a resident when needed. 47153 Based on observation, interview, and record review, the facility failed to ensure two of two sampled Respiratory Care Practitioners (RCP 1 and RCP 2) were competent to set up and manage respiratory care equipment for three of six residents (Resident 8, Resident 6, and Resident 10) according to facility policy. This failure had the potential to result in contaminated respiratory equipment being used and respiratory infections to develop in residents with compromised respiratory systems. Findings: During a concurrent observation and interview on 3/26/24 at 8:37 a.m. with Regulatory Registered Nurse (RRN) in Resident 8's room, corrugated tubing with oxygen flowing was laying on the floor. RRN stated the tubing is supposed to be placed into the clear bag when it has been disconnected from the resident, so it does not become contaminated. During an observation on 3/26/24 at 8:43 a.m. in Resident 6's room, corrugated tubing was laying on Resident 6's empty bed. During an observation on 3/26/24 at 8:44 a.m. in Resident 10's room, corrugated tubing was laying on Resident 10's empty bed and touching the headboard. During an interview on 3/26/24 at 8:48 a.m. with RCP 1, RCP 1 stated staff should have placed the tubing in the clear plastic bag that hangs at each resident's bedside when the resident is disconnected from the tubing. During an interview on 3/26/24 at 2:20 p.m. with Infection Preventionist (IP), IP stated it was unacceptable for tubing to be placed on the resident's bed and not changed. IP stated the RCP should have changed the tubing when they were notified it had been contaminated. During an interview on 3/26/24 at 3:18 p.m. with RCP 1, RCP 1 stated she changed the corrugated tubing for Resident 10 and Resident 8 but not for Resident 6. RCP 1 stated the tubing should have been changed before Resident 6 was reconnected because it was contaminated. RCP 1 stated weekly tubing changes are documented but not the as needed (PRN) tubing changes. RCP stated when tubing is changed, the water trap (drain cup used to collect excess water in the tubing caused by humidification) is dated. During an observation on 3/26/24 at 3:20 p.m. in Resident 10's room, tubing was checked for a date, the date on the water trap was 3/21, indicating the tubing had not been changed. During a concurrent observation and interview on 3/27/24 at 9:05 a.m. with RCP 2 in Resident 10's room, the water trap was dated 3/21. RCP 2 stated water trap is supposed to be changed when the tubing is changed because the tubing connects to the water trap and if the tubing is contaminated so is the water trap. RCP 2 stated the tubing and water trap should have been changed. RCP 2 stated RCPs do not document PRN tubing changes, only the weekly changes. RCP 2 left Resident 10's room and did not change tubing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555766	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Medical Center	465 W Putnam Ave Porterville, CA 93257

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 - Some	During an interview on 3/27/24 at 9:37 a.m. with IP, IP stated the tubing, including the water trap or drain cup should have been changed and documented. IP stated RCP 2 should have changed it when it was brought to his attention. IP stated staff did not follow the policy. During a concurrent interview and record review on 3/27/24 at 12:13 p.m. with Manager of Respiratory Care Services (MRCS), RCP 1's 2023 Annual Competency Review Respiratory Care Services (2023 ACRRCS), dated 10/4/23 and RCP 2's 2023 ACRRCS, dated 10/5/23 were reviewed. The competency did not include evaluation of RCP's ability to maintain infection control practices during the set up and changing of the tubing. MRCS stated the initial and annual competencies do not cover those practices because they are expected to know how to set up the tubing in a way that prevents infections as a part of their basic training. MRCS stated that should have been a part of the competency and needs to be incorporated. MRCS stated the 2023 ACRRCS did not evaluate RCP 1 or RCP 2 for the set up and management of respiratory equipment. MRCS stated it is an issue because the residents are high risk for serious respiratory infections. During a review of the facility's P&P titled, Competency Assessment Process, (undated), the P&P indicated, Annual competency assessment may include validation of the following . High-risk, low-volume job functions and accountabilities . Competencies will reflect the employee's job description, focuses on performance standards and behaviors necessary to perform core job functions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555766	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Medical Center	465 W Putnam Ave Porterville, CA 93257

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 - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47444 Based on observation, interview, and record review, the facility failed to ensure physician's ordered medication was available for administration to one of 30 sampled residents (Resident 17). This failure resulted in Resident 17 not receiving medication to reduce excessive stomach acid. Findings: During a review of Resident 17's Active Orders (AO), dated 3/28/24, the AO indicated, Pantoprazole [Protonix - medication used to decrease the amount of stomach acid] 40 mg [milligrams] GT [gastric tube - a tube inserted directly into the stomach through the abdominal wall, for administration of nutrition and medication] QDAY [every day]. During a concurrent observation and interview on 3/27/24 at 9:14 a.m. with Licensed Vocational Nurse (LVN) 3 outside of Resident 17's room, LVN 3 was preparing medications to be administered. LVN 3 stated Resident 17's dose of Protonix was not available in the facility to be administered. During a concurrent interview and record review on 3/28/24 at 9:26 a.m. with Registered Nurse (RN) 2, the Pharmacy Order/Change Form (POF), dated 3/26/24 was reviewed. The POF indicated Protonix was ordered from the pharmacy on 3/26/24. RN 2 stated the facility had not received the medication yet. During a review of the faciliy's policy and procedure (P&P) titled, Medication Administration - DP/SNF (undated), the P&P indicated, To assure the most complete and accurate implementation of physicians' medication orders and to optomize drug therapy for each resident by providing for administration of drugs in an accurate, safe, timely, and sanitary manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555766	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Medical Center	465 W Putnam Ave Porterville, CA 93257

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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 40516 Based on interview and record review, the facility failed to ensure the required language was written into signed arbitration agreements for two of 30 sampled residents (Resident 10 and Resident 12). This failure had the potential for Resident 10, Resident 12, and their representatives to not be aware of their rights to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health department employees and representative of the Office of the State Long Term Care Ombudsman. Findings: During an interview on 3/25/24 at 9:05 a.m. with Administrator/Director of Nursing (Admin/DON), Admin/DON stated the facility does not offer arbitration agreements. During a review of Resident 10's medical record, a signed arbitration agreement dated 6/29/19 was noted. The arbitration agreement did not have language regarding the right for Resident 10 or his representative to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health department employees and representative of the Office of the State Long Term Care Ombudsman. During a concurrent interview and record review on 3/27/24 at 3:33 p.m. with Admin/DON, Admin/DON stated the facility has no arbitration agreement policy because residents are not being asked to sign one during the admission process. Admin/DON reviewed Resident 10's signed admission agreement and stated he did have a signed arbitration agreement. During a concurrent interview and record review on 3/27/24 at 4:50 p.m. with Social Services (SS), SS stated she found a signed arbitration agreement for Resident 12. The arbitration agreement was reviewed and lacked the language regarding the right for Resident 12 or his representative to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health department employees and representative of the Office of the State Long Term Care Ombudsman. The facility was requested for a copy of the policy and procedure for arbitration agreements, none was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555766	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Medical Center	465 W Putnam Ave Porterville, CA 93257

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. 47153 Based on observation, interview, and record review, the facility failed to follow standard infection control practices when staff did not: 1. Change the suction canister liner (containing respiratory secretions) when over three quarters full for one of six sampled residents (Resident 21). 2. Change the Yaunker (suction catheter used to clear excess secretions from the mouth) per policy for one of six sampled residents (Resident 9). 3. Discard an unlabeled, undated, and contaminated T-piece (connection device used in oxygen delivery) for one of six sampled residents (Resident 10). 4. Store and secure aerosol tubing (oxygen delivery system) in a way that prevented contamination for three of six sampled residents (Resident 8, Resident 10, and Resident 6). 5. Discard and replace contaminated aerosol tubing before reconnecting for two of three sampled residents (Resident 6 and Resident 10). 6. Perform hand hygiene for two of two sampled residents (Resident 20 and Resident 2) while providing care. These failures had the potential to result in respiratory infections in residents with compromised respiratory systems. Findings: 1. During a concurrent observation and interview on 3/25/24 at 9:49 a.m. with Registered Nurse (RN) 1, in Resident 21's room, the suction canister was filled to 800 milliliters (ml). Resident 21 was coughing and had sputum filling his tracheostomy (opening in the airway from outside the neck to allow for breathing) tubing and dripping from the end of it. RN 1 stated Resident 21 should have been suctioned. RN 1 stated the suction canister should have been changed when it was three quarters full. During an interview on 3/26/24 at 8:36 a.m. with Administrator/Director of Nursing (Admin/DON), Admin/DON stated her expectation is for the cannister to be changed at the time it reaches 750 ml. 2. During a concurrent observation and interview on 3/25/24 at 9:38 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 9's room, an open Yaunker was on the over bed table. CNA 1 stated the package had been opened and was dated as opened 3/20/24. During an interview on 3/25/24 at 9:40 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated the Yaunker was opened and dated 3/20/24. LVN 2 stated since it was opened, it should have been replaced 3/23/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555766	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Medical Center	465 W Putnam Ave Porterville, CA 93257

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 and interview on 3/26/24 at 8:20 a.m. with LVN 1 in Resident 10's room, a T-piece with dried mucus was hanging at the bedside in a clear plastic bag with no name and no date. LVN 1 stated the bag should have been labeled and dated. During an interview on 3/26/24 at 8:33 a.m. with Respiratory Care Practitioner (RCP) 1, RCP 1 stated because the T-piece hanging in bag was not labeled and dated, it should have been discarded and replaced. 4. During a concurrent observation and interview on 3/26/24 at 8:37 a.m. with Regulatory Registered Nurse (RRN) in Resident 8's room, corrugated tubing with oxygen flowing was laying on the floor. RRN stated the tubing is supposed to be placed into the clear bag when it has been disconnected from the resident so it does not become contaminated. During an observation on 3/26/24 at 8:43 a.m. in Resident 6's room, corrugated tubing was laying on Resident 6's empty bed. During an observation on 3/26/24 at 8:44 a.m. in Resident 10's room, corrugated tubing was laying on Resident 10's empty bed and touching the headboard. During an interview on 3/26/24 at 8:48 a.m. with RCP 1, RCP 1 stated staff should have placed the tubing in the clear plastic bag that hangs at each resident's bedside when the resident is disconnected. During an interview on 3/26/24 at 8:51 a.m. with RRN, RRN stated the staff should have put the tubing into the bag when the residents were disconnected because the tubing could become contaminated and cause respiratory infections. During an interview on 3/26/24 at 2:20 p.m. with Infection Preventionist (IP), IP stated it is unacceptable for tubing to be placed on the resident's bed and not get changed. IP stated the RCP should have changed the tubing when they were notified it had been contaminated. 5. During an interview on 3/26/24 at 3:18 p.m. with RCP 1, RCP 1 stated she changed the corrugated tubing for Resident 10 and Resident 8 but not for Resident 6. RCP 1 stated the tubing should have been changed before Resident 6 was reconnected because it was contaminated. RCP 1 stated weekly tubing changes are documented but not the as needed (PRN) tubing changes. RCP stated when tubing is changed, the water trap (drain cup used to collect excess water in the tubing caused by humidification) is dated. During an observation on 3/26/24 at 3:20 p.m. in Resident 10's room, tubing was checked for a date, the date on the water trap was 3/21, indicating the tubing had not been changed. During a concurrent observation and interview on 3/27/24 at 9:05 a.m. with RCP 2 in Resident 10's room, the water trap was dated 3/21. RCP 2 stated water trap is supposed to be changed when the tubing is changed because the tubing connects to the water trap and if the tubing is contaminated so is the water trap. RCP 2 stated the tubing and water trap should have been changed. RCP 2 stated RCPs do not document PRN tubing changes, only the weekly changes. RCP 2 left Resident 10's room and did not change tubing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555766	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Medical Center	465 W Putnam Ave Porterville, CA 93257

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	During a concurrent interview and record review on 3/27/24 at 9:37 a.m. with IP, the facility's policy and procedure (P&P) titled, Tracheostomy Care-DP [Distinct Part]/SNF [Skilled Nursing Facility], (undated), was reviewed. The P&P indicated, Attach tracheostomy to tubing of suction catheter at T-piece . Discard all contaminated items . INFECTION CONTROL . Change suction canister liners every three (3) days, odd rooms on night shift and even rooms on day shift. Change suction canister liners as needed when three (3) quarters full . Change Yaunkers every Tuesday and Saturday, if opened, and as needed. IP stated the tubing, including the water trap or drain cup should have been changed and documented. IP stated RCP 2 should have changed it when it was brought to his attention. IP stated staff did not follow the policy. During a review of the facility's P&P titled, Bland Aerosol Administration, (undated), the P&P indicated, INFECTION CONTROL. Management of the Bland Aerosol delivery system is performed in order to limit the occurrence of nosocomial infections [infections acquired inside of a healthcare setting, not present on admission] and to assure that the circuit maintains it's physical integrity. Aerosol set up, including tubing, drain cup and suction will be changed weekly and PRN, documented at the time of the change, on the patient treatment sheet by the Respiratory Care Practitioner. In addition, the new circuit will be dated at the time of change, usually on the drain cup itself. 47444 6. During an observation on 3/27/24 at 8:25 a.m. outside of Resident 20's room, LVN 4 did not perform hand hygiene before putting on gloves and going to Resident 20's bedside to administer medications. LVN 4 gave eyedrops to both of Resident 20's eyes, removed her gloves, put on new gloves without performing hand hygiene, then gave medications through Resident 20's gastrostomy tube (g-tube - tube inserted directly into the stomach through the abdominal wall, for administration of nutrition and medication). While wearing the same gloves used while handling Resident 20's g-tube, LVN 4 suctioned (way to clear the airway when the individual cannot clear it) Resident 20's airway through the tracheostomy. LVN 4 removed the gloves, did not perform hand hygiene, and put on new gloves to clean up and dispose of supplies on bedside table. During an observation on 3/27/24 at 8:49 a.m. outside Resident 2's room, LVN 4 did not perform hand hygiene before putting on gloves and going to Resident 2's bedside to give medications through Resident 2's g-tube. LVN 4 removed gloves after giving medications, without performing hand hygiene. LVN 4 put on new gloves to suction Resident 2's airway through the tracheostomy. LVN 4 removed the gloves, did not perform hand hygiene, and put on new gloves to clean up and dispose of supplies on bedside table. During an interview on 3/27/24 at 9:10 a.m. with LVN 4, LVN 4 stated she should have performed hand hygiene when taking off and putting on new gloves and between the g-tube and tracheostomy care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555766	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Medical Center	465 W Putnam Ave Porterville, CA 93257

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	During a concurrent interview and record review on 3/28/24 at 10 a.m. with Administrator/Director of Nursing (Admin/DON), the facility's P&P titled, Handwashing, (undated) was reviewed. The P&P indicated, Policy: All employees, volunteers, contractors, medical staff, students, and instructors shall wash their hands frequently with soap, friction, and running water or alcohol-based hand rub/sanitizer to minimize the likelihood of hands serving as a mode of transmission for healthcare acquired infections (HAI's). *Handwashing Indications . 2. Before and after performing invasive procedures 3. Healthcare Personnel (HCP) need to perform hand hygiene before and after all patient contact 4. Before and after taking care of particularly susceptible patients such as those who are severely immunocompromised [lacking ability to prevent or fight infection] . 6. After contact with potentially infectious material in situations during which microbial [germs] contamination of hands is likely to occur, especially those involving contact with mucous membranes, blood, body fluids, secretions, excretions, and/or other potentially infectious materials (OPIM) . Hand Hygiene Indications . 8. Decontaminate hands before donning (putting on) and after doffing (removing) gloves and reused PPE (mask, goggles/face shields and gowns). Admin/DON stated staff are expected to perform hand hygiene before and after glove use, to help prevent the spread of infection among residents.