STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555479	A. BUILDING _____ B. WING _____	**08/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DELANO DISTRICT SKILLED NURSING FACILITY	**1509 TOKAY STREET DELANO, CA 93215**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** Based on interview and record review, the facility failed to notify the Responsible Party (RP) for one of three sampled residents (Resident 1) of a change in condition when Resident 1 experienced a change in condition and was transferred to the hospital. This failure resulted in a violation of resident's rights. Findings: During an interview on 6/26/20, at 4:26 PM, with FM, FM stated, The facility did not let us know when Dad (Resident 1) was sent to the ER (emergency room). During an interview on 8/7/20, at 3:49 PM, with Registered Nurse (RN) 1, RN 1 stated she attempted to call Resident 1's wife multiple times to notify Resident 1 was to be sent to the hospital. RN 1 stated she sent Resident 1 promptly to the hospital and was caught in the middle of a lot of things, got busy, and had not called the family again. RN 1 stated she did not call the second contact person. During a review of the facility policy and procedure (P&P) titled, Change in Condition, dated 6/1/17, the P&P indicated, Notify legal representative/responsible party/family member/surrogate decision-makers of any changes in condition as soon as possible in accordance wit HIPAA guidelines.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.