STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555260	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bakersfield Post Acute	6212 Tudor Way Bakersfield, CA 93306

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 39763 Based on interview and record review, the facility failed to ensure one of seven sampled residents (Resident 1) was protected from physical and verbal abuse. This failure had the potential to result in physical and psychosocial harm for Resident 1. Findings: During a review of Resident 1's Minimum Data Set, (MDS - an assessment tool) dated 11/28/24, the MDS indicated, Resident 1's BIMS (Brief Interview for Mental Status) score was 3 (a score of 0-7 suggests the resident has severely impaired cognition). The MDS indicated Resident 1 needed substantial/maximal assistance (helper does more than half the effort) with sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed) and chair/bed to chair transfers (the ability to transfer to and from bed to a chair or wheelchair). During a review of Resident 2's Minimum Data Set, 12/12/24, the MDS indicated, Resident 2's BIMS score was 15 (a score of 13 to 15 suggests the resident is cognitively intact). The MDS indicated Resident 2 needed partial/moderate assistance helper does less than half the effort, helper lifts hold trunk or limbs but provides less than half the effort) with sit to stand, and chair/bed to chair transfers. During an interview on 2/18/25 at 3:41 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 1/31/25 he served Resident 1 and Resident 2 their breakfast and went to serve the rest of the breakfast trays. CNA 1 stated he went back to pick up meal trays and he heard Resident 2 mumbling and sounded agitated. CNA 1 stated he went into the room and saw Resident 2 standing over Resident 1's bed (Resident 1 was lying in bed) with his (Resident 2) hand in a fist over Resident 1's chest and in a downward motion Resident 2 hit Resident 1 in the chest. CNA 1 stated he separated Resident 1 and Resident 2 and reported the incident to Licensed Vocational Nurse (LVN) 2 and LVN 3. During an interview on 2/19/25 at 10:21 a.m. with CNA 2, CNA 2 stated she was assigned to Resident 1 and Resident 2 on 1/30/25. CNA 2 stated when went to Resident 1 and Resident 2's room, she heard Resident 2 yelling at Resident 1 telling Resident 1 to Shut the F. up (Resident 1)! CNA 2 stated she reported to LVN 1, Resident 2 was yelling and cussing at Resident 1. CNA 2 stated LVN 1 did not intervene, LVN 1 did not separate or protect Resident 1 from Resident 2. CNA 2 stated if LVN 1 would have intervened when Resident 2 was yelling and cussing at Resident 1 maybe the physical abuse on 1/31/25 could have been avoided. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, the P&P indicated, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from . verbal, mental, . physical abuse, .The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: . other residents; . 2. Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment of residents; . 5. Identify and investigate all possible incidents of abuse . 6. Investigate and report any allegation . Protect residents from any further harm during investigations.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 39763 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, when the facility failed to: 1. Submit the SOC 341(Report of Suspected Dependent Adult/Elder Abuse) timely to California Department of Public Health (CDPH-local stated agency) and local ombudsman for two of four sampled residents (Resident 1 and Resident 2). This failure resulted in the allegation of abuse not being reported to CDPH and the local ombudsman timely. 2. Thoroughly investigate resident to resident physical abuse for two of four sampled residents (Resident 1 and Resident 2). This failure had the potential to result in an incomplete investigation. Findings: 1. During a concurrent interview and record review on 2/24/25 at 11:53 a.m. with Director of Nursing (DON), DON confirmed a Resident-to-Resident physical abuse between Resident 1 and Resident 2 happened on 1/31/25. DON was unable to provide evidence the SOC 341 was submitted to CDPH and local ombudsman within 24 hours. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022, the P&P indicated, All reports of resident abuse . are reported to local, state and federal agencies. 1. If resident abuse, .is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; . 3.Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. 4. Verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone. During a review of the facility provided document titled, SOC 341, revised 2/2024, the document indicated, Report Of Suspected Dependent Adult/Elder Abuse General Instructions . Reporting Responsibilities And Time Frames: . In all other of abuse that occurred in a Long-Term Care (LTC) facility . a verbal report shall be made by telephone to the local law enforcement agency immediately and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to local law enforcement agency, the local Long-Term Care Ombudsman Program (LTCOP), and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health . within twenty-four (24) hours of observing, obtaining knowledge of or suspecting physical abuse. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview on 2/24/25 at 11:53 a.m. with DON, DON confirmed she was responsible for the investigation of the resident-to-resident physical abuse for Resident 1 and Resident 2 on 1/31/25. DON confirmed the incident took place at 8 a.m. right after change of shift. DON stated she interviewed the Certified Nursing Assistant (CNA) who witnessed Resident 2 striking Resident 1 on the chest, the charge nurse on duty and Resident 1 and Resident 2. DON stated no other staff or residents were interviewed. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022, the P&P indicated, Investigating Allegations 1. All allegations are thoroughly investigated. 7. The individual conducting the investigation as a minimum: .d. interviews the person(s) reporting the incident; . h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; . k. reviews all events leading up to the alleged incident; .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 39763 Based on interview and record review, the facility failed to consistently implement Interdisciplinary Team (IDT- a group of health care professionals with various areas of expertise who work together to improve patient safety and outcomes) recommendation for two of four sampled residents (Resident 1 and Resident 2). This failure had the potential for Resident 1 and Resident 2's physical and psychosocial needs to be unmet. Findings: During a review of the facility provided document titled, Resident to Resident (Resident 1 and Resident 2) Altercation Investigation, dated 1/31/25, the document indicated, 5-Day Follow-Up (February 05, 2025) . 3. Monitor for mood and delayed signs/symptoms of injury related to altercation. During a review of Resident 1's IDT Note, dated 1/31/25, the IDT note indicated Resident 1 was involved in a Resident-to Resident physical altercation with Resident 2. The IDT note indicated, the IDT recommendation: . Monitor for mood and delayed signs/symptoms of injury related to altercation. During a concurrent interview and record review, on 2/24/25 at 11:53 a.m. with Director of Nursing (DON), DON stated both Resident 1 and Resident 2 were monitored for physical and psychosocial outcomes. DON reviewed Resident 1's medical record and confirmed no physical or psychosocial monitoring was documented on 2/1/25 to 2/4/25. DON reviewed Resident 2's medical record and confirmed monitoring was not documented on 2/1/25 to 2/4/25. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised March 2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. The interdisciplinary team (IDT), . develops and implements a comprehensive, person-centered care plan for each resident. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, . 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; .