

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Bakersfield Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>50409</p> <p>Based on interview and record review, the facility failed to ensure medications were administered according to the physician's orders (PO) for one of three sampled residents (Resident 1) when Resident 1 did not receive two medications on time. This failure had the potential to result in Resident 1 developing adverse health outcomes due to delay in receiving his medications.</p> <p>Findings:</p> <p>During a review of Resident 1's Order Summary Report, dated 3/26/25, the OSR indicated, Apixaban (medication that helps the blood flow more easily). two times a day for ATRIAL FIBRILLATION (irregular, often rapid heart rhythm) . Metoprolol (medication to treat high blood pressure). two times a day for HYPERTENSION (high blood pressure).</p> <p>During a review of Resident 1's Brief Interview for Mental Status (BIMS), dated 3/20/25, the BIMS indicated Resident 1 had a score of 15 (cognitively intact).</p> <p>During an interview on 3/26/25 at 2:34 p.m. with Resident 1, Resident 1 stated on 3/16/25, he was supposed to be administered his Metoprolol and Apixaban at 9 a.m. but were administered to him at around 12:30 p.m. Resident 1 stated at 9 a.m. Licensed Vocational Nurse (LVN) 1 checked his blood pressure and it was a little bit high due to him feeling excited trying to get the nurse to give him his medications because LVN 1 told him his Metoprolol and Apixaban were not in the medication cart.</p> <p>During a concurrent interview and record review on 3/26/25 at 4:10 p.m. with Director of Nursing (DON), Resident 1's EMAR (Electronic Medication Administration Record), dated 3/16/25 was reviewed. The EMAR indicated Resident 1 was administered Metoprolol and Apixaban at 12 p.m. Resident 1's PO, dated 3/26/25 were reviewed. The PO indicated Resident 1's Metoprolol and Apixaban were scheduled at 9 a.m. DON stated, (Metoprolol and Apixaban) were not administered at the time the physician ordered. DON stated medications should be administered one hour before and one hour after the prescribed time.</p> <p>During a concurrent interview and record review on 3/26/25 at 4:57 p.m. with DON, the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019 was reviewed. The P&P indicated, Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). DON stated the P&P was not followed.</p> <p>(continued on next page)</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/3/25 at 4:54 p.m. with LVN 1, LVN 1 stated she was the nurse assigned to Resident 1 on 3/16/25 day shift. LVN 1 stated on 3/16/25, Resident 1's Metoprolol and Apixaban were not in the medication cart and had to be taken out from the cubex (machine that dispenses medications). LVN 1 stated she administered Metoprolol and Apixaban to Resident 1 at 12 p.m. LVN 1 stated Resident 1's blood pressure at 9 a.m. was high, but she did not document it. LVN 1 stated, It wasn't 120/80. It was above 130. LVN 1 stated she was supposed to administer Metoprolol and Apixaban to Resident 1 at 9 a.m. according to the PO. LVN 1 stated the PO was not followed.</p>		