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	04/22/2025

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. 39763 Based on interview and record review, the facility failed to follow its policy and procedure for Access to Personal and Medical Records, for one of three sampled residents (Resident 1). This failure resulted in violation of Resident 1's rights. Findings: During a concurrent interview and record review, on 4/15/25 at 12:39 p.m. with Medical Records Director (MRD), Resident 1's Authorization to Release Medical Records, (ARMR) dated 3/31/25 (Monday), signed by Resident 1 was reviewed. MRD stated the ARMR did not indicate the request was for legal reason and the medical records request was made by Resident 1. Resident 1's Certified Mail Receipt, dated 4/15/25 (15 days after ARMR was submitted) was reviewed. MRD stated Resident 1's medical record should been provided to Resident 1 within two business days. During a review of the facility's policy and procedure (P&P) titled, Access to Personal and Medical Records, revised May 2017, the P&P indicated, Each resident has the right to access and /or obtain copies of his or her personal and medical records upon request. 5. The resident may obtain a copy of his or her personal or medical record within two business days of an oral or written request.

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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 39763 Based on interview and record review, the facility failed to provide sufficient staffing for one of three sampled residents (Resident 2), when call lights were not answered timely. This failure resulted in delay in meeting Resident 2's basic needs and potential for emotional distress. Findings: During a review of Resident 2's Minimum Data Set, (MDS - an assessment tool) dated 3/10/25, the MDS indicated Resident 2's BIMS (Brief Interview for Mental Status) score was 15 (13 to 15 points indicates the resident has cognitive intactness). The MDS indicated Resident 2 needed substantial/maximal assistance (helper does more than half the effort) for toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement) and Resident 2 was dependent (helper does all the effort) for toilet transfer (the ability to get on and off the toilet or commode). The MDS indicated Resident 2 was always continent (the ability to control one's bladder) of urine. During a review of Resident 2's care plan with the focus on ADL/Mobility, revised on 5/15/24. The care plan indicated interventions included Toileting: substantial . Transfer: substantial . Resident 2's care plan with the focus on Skin: (Resident 2) is at risk for skin breakdown ., initiated 11/24/24. The care plan indicated one of the interventions was to Keep skin clean and dry to the extent possible. During an observation and interview on 4/15/25 at 11:26 a.m. with Resident 2, in Resident 2's room. Resident 2 stated on the evening shift (2:30 p.m. to 10:30 p.m.) last night (4/14/25) he could not get any help. Resident 2 stated call light wait times range from 20 minutes to two hours sometime on evening and night shift. Two clocks were observed across from his bed. Resident 2 stated he usually pressed his call lights on and looked at the clock. Resident 2 stated on 4/14/25, he placed his urinal on the nightstand for the Certified Nursing Assistant (CNA) to empty. Resident 2 stated he pressed the call light because he had to urinate, and his urinal was almost full. Resident 2 stated he takes medication making him urinate. Resident 2 stated he waited 40 minutes for the CNA to answer his call light. Resident 2 stated he was holding his urine, and he was in pain. Resident 2 stated he had to turn over in bed and urinate into the almost full urinal and he urinated on his self and his bedding. Resident 2 was noted upset, and his voice was gravely with emotion. Resident 2 stated, THEY WILL NOT COME! Resident 2 stated, I would not treat a dog the way they treat people around here. Resident 2 stated the night shift (10 p.m. to 6:30 a.m.) CNA had to change my bedding. Resident 2 stated, I felt worthless I wanted to cry. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/25 at 3:14 p.m. with CNA 1, CNA 1 stated he worked night shift on 4/14/25. CNA 1 stated Resident 2's bed was soiled and changed it. CNA 1 stated on night shift he was assigned to 15-24 residents. CNA 1 stated he was assigned to 24 residents at least 2 to 3 times a month. CNA 1 stated there were times the residents call lights were answered late because he was providing care in a resident's room and when he came out of the room there were nine call lights on. CNA 1 stated he could not answer call lights timely, and the residents were very upset because they had waited for two hours for their call lights to be answered. CNA 1 stated he was unable to take his 10-minute breaks due to his workload. During an interview on 4/16/25 at 3:28 p.m. with CNA 2, CNA 2 stated on the evening shift she was assigned 12 to 20 residents. CNA 2 stated short staffing was very common, she stated the facility was unstaffed at least six times a month. CNA 2 stated sometimes it was really hard to meet the residents' needs. CNA 2 stated she was in a hurry most of the time and could not take her breaks, she stated she often had to skip her 10-minute breaks. During a review of the facility's policy and procedure (P&P) titled, Staffing And Sufficient Nursing, revision date August 2022, the P&P indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills necessary to provide nursing and related care and services for all residents in accordance with resident care plans and facility assessments. 1. Licensed nurses and certified nursing assistance are available 24 hours a day, seven (7) days a week to provide competent resident care and services including: b. attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident; c. assessing, evaluating planning and implementing resident care plans .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 39763 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 2) medical records were accurate. This failure had the potential to affect the continuity of care for Resident 2. Findings: During an interview on 4/16/25 at 3:14 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 2 had a green sticker on his door and the green sticker indicated Resident 2 was on fluid restriction (limiting the amount of fluids a person can drink). During a review of Resident 2's active care plan with the focus on The (Resident 2) has fluid overload (occurs when there is too much fluid in the body, leading to swelling and other complications), revised on 11/14/23. The care plan indicated interventions were, Fluid restriction 1500ml (milligram-unit of measure) per day. During a concurrent interview and record review, on 4/22/25 at 2:15 p.m. with Director of Nursing (DON), Resident 2's active orders were reviewed. DON stated Resident 2 did not have an active order for fluid restriction. DON stated Resident 2's fluid restrictions order was discontinued on 1/22/24 and the care plan should have been discontinued then (1/24/24). During a review of the facility's policy and procedure (P&P) titled, Documentation Accuracy In The Health Record, undated, the P&P indicated, Clinical records should accurately reflect the care given by each member of the health care team as well as the response of the person receiving services. For the resident, the clinical record should ensure continuity of care; for the staff, it assists in coordination of services .