STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555517	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kern Valley Healthcare District Dp Snf	6412 Laurel Ave Lake Isabella, CA 93240

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. (continued on next page)

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy and procedure on narcotic (pain medication) count, narcotic dispensing, and storage for one of three sampled residents (Resident 1). This failure resulted in missing narcotic medications and had the potential to affect Resident 1's pain control. During a review of the facility email (FEM), dated 6/24/25, the FEM indicated Resident 1's narcotic medications (morphine - a narcotic pain medication) were placed into the medication room on 6/11/25 but were not double locked in the narcotics drawer. Licensed Vocational Nurse (LVN) 1 accessed Resident 1's home medications during her evening shift (7 p.m. to 7:30 a.m.) to administer one morphine ER (extended release - medication that is released into the body over a period of time) 15 mg (milligram - a unit of measurement) pill to Resident 1. The FEM indicated, The (Resident 1's morphine) should not have been used, and the staff should have notified the provider (medical doctor) to see if an alternative pain medication . could be used to control (Resident 1's) pain. The FEM indicated, (The facility) received a new (admission) from Acute (hospital) on 6/11/25 (at 1:05 p.m.) . Resident (1) came over with a large bag of 'at home' Narcotics . (Resident 1's) at home medications sheet (a sheet that keeps count of medications) was folded and placed in the (Resident 1's) bag. The bag was placed in the (medication) room by (Registered Nurse - RN 1). (RN 1's) name is printed as the (receiving) Nurse. However (sic) no signature was on the sheet. When I (unknown person) came on shift today I noticed the bag sitting on the med room counter and (unknown person) mentioned that (LVN 1) used (Resident 1's) at home (medications) instead of pulling from the Ekit (a container that holds different medications in case of emergency). The (medications) were counted and it was noted that the Morphine 15mg tabs were 67 in one bottle 1 used on (LVN 1's) shift (totaling 68) and the count on acute (hospital) care sheet stated 44 + 39 (83). That would make a discrepancy of 15 (pills) short. The (Acute Care Nurse - ACN) and (Facility Pharmacist - FP) from acute (hospital) should have counted before (Resident 1) left acute (hospital) and then counted with the (facility) receiving (RN 1).During an interview on 6/25/25 at 11:47 with Director of Nursing (DON), DON stated Resident 1 was admitted to the facility from the acute hospital (the facility and acute hospital share the same building) on 6/11/25. Resident 1's home medications including morphine were brought in by family and counted by the acute hospital staff. DON stated when Resident 1 was discharged from the acute hospital portion of the facility, RN 1 (facility RN) picked up Resident 1 from the acute hospital (via gurney) and was given Resident 1's home narcotic medications (morphine) from ACN. DON stated a count of Resident 1's narcotics medications was not done during the exchange from acute care to the facility. DON stated RN 1 placed Resident 1's narcotic medications (morphine) into the facility medication room but not stored in a locked area as it should have been. DON stated a count of Resident 1's narcotic medication (morphine) was not done until the next day (6/12/25). DON stated when Resident 1's narcotic medications were counted on 6/12/25 by Assistant Director of Nursing (ADON), 15 morphine ER 15 mg pills were found to be missing from the 83 pills she had brought in from home. During an interview on 6/25/25 at 12:15 p.m. with ADON, ADON stated on 6/12/25 she counted Resident 1's narcotic medications (morphine) in the facility medication room. ADON stated Resident 1's narcotic medications were on the counter and not double locked as they should have been. ADON stated she counted the medications and found 15 morphine ER 15 mg pills were missing. ADON stated she called FP, and FP verified 15 morphine ER 15 mg pills were missing. During a review of Resident 1's admission RECORD (AR), dated 6/25/25, the AR indicated, Resident 1 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD - a group of lung conditions that make it hard to breathe), major depressive disorder (a serious mental health condition characterized by feelings of sadness, loneliness, and hopelessness), wedge compression fracture (a type of spinal break in bone of unspecified where part of the bone collapses or [NAME] in) of lumbar vertebra (lower back), and cachexia (condition characterized by the loss of muscle and fat mass). During a review of Resident 1's Minimum Data Set (MDS) Assessment (a standardized assessment to evaluate a resident's functional abilities and healthcare needs), dated 6/19/25, under the section titled, Brief Interview for Mental Status (BIMS - an assessment of cognition [how well a person thinks, remembers, and learns]), the BIMS score was 15 (cognition intact).During an interview on 6/25/25 at 12:32 p.m. with Resident 1, Resident 1 stated she was taking narcotic medication to control pain from COPD and a fracture (broken bone) in her spine. During an interview on 6/25/25 at 1:16 p.m. with Risk Manager (RM), RM stated during Resident 1's transfer from the