

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555771	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/29/2025
NAME OF PROVIDER OR SUPPLIER  Brookdale Riverwalk Snf (CA)		STREET ADDRESS, CITY, STATE, ZIP CODE  350 Calloway Drive, Building C Bakersfield, CA 93312	

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 0656  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.  (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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to develop and implement a care plan (a detailed, written document created by facility staff that outlines all the medical, physical, emotional, and social care a resident will receive to improve or maintain their quality of life) for one of three sampled residents (Resident 1) with visual hallucinations (the experience of sensing something that is not actually there, even though it seems very real). This failure had the potential to result in Resident 1's care needs to not be met and/or result in psychological harm. Findings: During a review of Resident 1's admission RECORD (AR), dated 7/30/25, the AR indicated, Resident 1 was admitted to the facility on [DATE] with a diagnosis of unspecified dementia (a decline in mental ability severe enough to interfere with daily activities and decision-making, impacting core cognitive functions like memory, language, attention, reasoning, and social skills) unspecified severity with other behavioral disturbance, history of falling, and quadriplegia (partial or total loss of function, movement, and sensation in all four limbs and the torso). 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 7/21/25, 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 6 (severe cognitive impairment). During a concurrent observation and interview on 7/29/25 at 2:36 p.m. with Resident 1 in Resident 1's room. Resident 1 was observed lying on her right side facing a window with a clear view of the outside and no one was observed to be there. Resident 1 stated, I'm (Resident 1) telling you someone keeps trying to climb through that (her) window. It's three guys and they keep trying to come in. I don't know why they keep trying to keep in. Resident 1 was not able to describe the three men she was seeing. Resident 1 kept repeating there were three men outside her window, and they were at the edge of the window trying to enter despite no one being there. Resident 1 stated the last time the three men tried to enter was the day before (7/28/25) but could not state at what time. During an interview on 7/29/25 at 3 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 has been having episodes of hallucinations for approximately three weeks. LVN 1 stated Resident 1 has episodes of confusion and sees things that were not there. LVN 1 stated the biggest thing Resident 1 sees is people in her room and/or people trying to get into her room through the window that were not there. During an interview on 7/29/25 at 3:20 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 had been seeing people outside her window that were not there and attempted to go into her room. CNA 1 stated Resident 1 had been having these hallucinations for two or three months. CNA 1 stated other CNA's (not specific), and nurses (not specific) are aware of Resident 1's hallucinations. During a concurrent interview and record review on 7/29/25 at 3:48 p.m. with Administrator, Resident 1's Electronic Medical Record (EMR), was reviewed. Administrator stated she was not aware of Resident 1's hallucinations about people trying to enter her room through her window. Administrator reviewed Resident 1's EMR and stated there was no care plan developed for Resident 1's hallucinations. Administrator stated there should be a care plan developed for Resident 1's hallucinations. During an interview on 7/29/25 at 3:52 p.m. with Social Services Director (SSD), SSD stated she was not aware of Resident 1's hallucinations. SSD stated she should have been made aware. During a review of the facility's policy and procedure (P&amp;P) titled, Comprehensive Care Plan, dated 11/2017, the P&amp;P indicated, A comprehensive, person-centered Care Plan will be developed for each resident that includes measurable objectives and timeframes to meet the resident's medical, nursing, mental and psychosocial needs that have been identified through a comprehensive assessment. A person centered, comprehensive care plan will be developed and implemented in accordance with the following . The Comprehensive Care Plan will describe treatments and services to assist the resident to . attain or maintain the highest level of physical, mental and psychosocial wellbeing. Each resident's comprehensive care plan will describe . Identified resident issues, conditions, risk factors and safety issues . Person centered measurable objectives and timeframes that will be used to evaluate progress toward goals. Interventions that will be implemented to enable each resident to meet his/her objectives.</p>		