STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555771	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Riverwalk Snf (CA)	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 133) right to refuse was respected. This failure resulted in a violation of Resident 133's right to be treated with respect and dignity.Findings:During an interview on 12/1/25 at 7:54 a.m. with Certified Nursing Assistant (CNA) 5, CNA 5 stated Resident 133 had dried poop all over her bottom. CNA 5 stated Resident 133 did not want her brief changed; CNA 5 stated she could not leave Resident 133 in her brief because there was a lot of poop and Resident 133 was unstable. CNA 5 stated she cleaned and changed Resident 133's brief and Resident 133 was screaming during the brief change. CNA 5 stated, I should have left (Resident 133) because (Resident 133) was screaming. During an interview on 12/2/25 at 11:14 a.m. with the Administrator, Administrator stated during an interview with CNA 5, CNA 5 stated she was assisting Resident 133 in the restroom; Resident 133 was standing up and had a large bowel movement and CNA 5 was able to undo the brief and put a new one on but the whole time Resident 133 was standing up saying no. During a review of the facility's policy and procedure (P&P) titled, Quality of Life -Dignity, last revised 10/2025, the P&P indicated, Residents should be cared for in a manner that promotes and enhances their sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. 1. Residents should be treated with dignity and respect. 2. The community culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's community stay.

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on interview and record review, the facility failed to ensure two of three sampled residents (Resident 47 and Resident 101) were provided with 72 hour written notification prior to receiving a new roommate. These failures resulted in a violation of residents' rights.Findings:During a review of Resident 37's Progress Note (PN) dated 11/9/25 at 10:32 a.m., the PN indicated, Room change update: Resident [37] was temporarily moved from 103-A to 107-A the evening of 11/8/25 due to incompatible roommate. Resident [37] will be moved to 121-B.During a review of the Action Summary (AR-report used to identify room changes that have been made) dated 12/2/25 at 1:16 p.m., the AR indicated (Resident 37) was moved from 103-A to 107-A on 11/8/25 and moved from 107-A to 121-B on 11/9/25.During an interview on 12/3/25 at 8:40 a.m. with Social Service Director (SSD), SSD stated when a new roommate was to be received, the notification was done informally, and nothing was documented.During an interview on 12/3/25 at 8:48 a.m. with admission Coordinator (AC), AC stated when a new roommate was to be received, the resident was informed verbally and nothing was documented.During an interview on 12/3/25 at 3:52 p.m. with Administrator, Administrator stated when a resident receives a new roommate, the receiving roommate should have advanced notice, and it should be documented.During a concurrent interview and record review, on 12/4/25 at 9:24 a.m. with SSD, Resident 47 and Resident 101's clinical records were reviewed. SSD stated Resident 37 was moved into a room with Resident 47 on 11/8/25 and moved into a room with Resident 101 on 11/9/25. SSD was unable to provide evidence of Resident 47 and Resident 101 being notified of receiving a roommate prior to the move.During a review of the facility's policy and procedure (P&P) titled, Room Change/Roommate Assignment dated 10/2021, the P&P indicated, Prior to changing a room or roommate assignment all parties involved in the change/assignment (e.g., residents and their representatives) are given a 72 hour/day [sic] advance written notice of such change. A. Advance written notice of a roommate change includes why the change is being made and any information that will assist the roommate in becoming acquainted with his or her new roommate.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to implement their policy and procedure (P&P) titled, Abuse, Neglect & Exploitation Policy when allegations of abuse were not reported within 24 hours to the California Department of Public Health (CDPH-local state agency) and local ombudsman (representatives assist residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences) for one of three sampled residents (Resident 133). This failure resulted in Resident 133's allegation of abuse not being reported to CDPH and the local ombudsman timely. Findings:During a review of the facility provided document titled, Re: Allegations of Abuse, dated 11/13/25, the document indicated, 11/06/2025 1500 [3 p.m.] - The [Certified Nursing Assistant (CNA) 5] . assist [Resident 133] to the restroom. [CNA 5] enters restroom with [Resident 133]. [Resident 133] pulls down her pants and brief to urinate and [CNA 5] noticed [Resident 133] had a bowel movement. [CNA 5] attempts to change [Resident 133's] brief and [Resident 133] does not want to change brief. [Resident 133] exited the restroom and asks [Visitor] to take her to talk to someone. [Visitor] brings [Resident 133] to the Director of Clinical Services, [DCS]. [DCS] speaks with [Resident 133] and [CNA 5] [DCS] explains to [Resident 133] that [CNA 5] was providing care. 11/07/25 - [Resident 133] calls her daughter . and tells her a CNA hit her. 11/08/25 1000 [10 a.m.] [Family Member (FM) 2] calls the facility and speaks with Receptionist . [FM 2] tells [Receptionist] her [Resident 133] called her yesterday and told her a CNA hit her.During an interview on 12/1/25 at 7:54 a.m. with CNA 5, CNA 5 stated she witnessed Resident 133 making allegations of physical abuse to the DCS (approximately 11/5/25 or 11/6/25). During an interview on 12/2/25 at 11:14 a.m. with Administrator, Administrator stated during the investigation Resident 133's allegations of physical abuse made on 11/8/25, the DCS stated on 11/6/25, Resident 133 informed her that CNA 5 was rough with her during care. Administrator stated when she interviewed CNA 5, CNA 5 stated she witnessed Resident 133 making allegations of physical abuse by CNA 5 to the DCS. Administrator stated the abuse allegation was not reported to her, CDPH, or the local ombudsman until 11/8/25 (two days later). During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect & Exploitation Policy, revised 10/22, the P&P indicated, Instances or allegations of abuse, neglect, mistreatment or exploitation should be treated seriously and reported to the administrator or the supervisor on duty for investigation and appropriate follow-up. G. External Reporting 1. Alleged violations involving abuse, neglect, exploitation or mistreatment . should be reported: a. As soon as practical, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or . b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. c. Such alleged violation shall be reported to: i. The State Survey Agency .3. Refer to the reporting Suspected Crimes under the Elder Justice Act policy for additional External Reporting requirements.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed follow their policy and procedure (P&P) titled, Abuse, Neglect & Exploitation Policy, when the facility failed to investigate and protect one of three sampled residents (Resident 133) when allegations of physical abuse were made. These failures had the potential for Resident 133's allegation not to be investigated timely and Resident 133 not to be protected from further abuse. Findings: During a review of the facility provided document titled, Re: Allegations of Abuse, dated 11/13/25, the document indicated, 11/06/2025 1500 (3 p.m.) - The [Certified Nursing Assistant (CNA) 5] . assist [Resident 133] to the restroom. [CNA 5] enters restroom with [Resident 133]. [Resident 133] pulls down her pants and brief to urinate and [CNA 5] noticed [Resident 133] had a bowel movement. [CNA 5] attempts to change [Resident 133's] brief and [Resident 133] does not want to change brief. [Resident 133] exited the restroom and asks [Visitor] to take her to talk to someone. [Visitor] brings [Resident 133] to the [DCS]. [DCS] speaks with [Resident 133] and [CNA 5] (DCS) explains to (Resident 133) that [CNA 5] was providing care. 11/07/25 - [Resident 133] calls her daughter . and tells her a CNA hit her. 11/08/25 1000 [10 a.m.] [Family Member (FM 2]) calls the facility and speaks with Receptionist . [FM 2] tells [Receptionist] her [Resident 133] called her yesterday and told her a CNA hit her .During an interview on 12/1/25 at 7:54 a.m. with CNA 5, CNA 5 stated she assisted Resident 133 in the restroom Resident 133 did not want her brief changed. CNA 5 stated Resident 133 was screaming during the brief change. CNA 5 stated that day she witnessed Resident 133 making allegations of physical abuse to the DCS. CNA 5 stated she told the DCS she was assigned to Resident 133, and no one hit or beat Resident 133 that she (Resident 133) was just confused. CNA 5 stated the DCS told her to go and continue working.During a review of CNA 5's timecard dated 11/6/25, the time card indicated CNA 5 worked from 1:57 p.m. to 9:57 p.m. During an interview on 12/2/25 at 11:14 a.m. with Administrator, Administrator stated during the investigation of Resident 133's allegations on abuse on 11/8/25, she discovered that Resident 133 made allegations of physical abuse against CNA 5 on 11/6/25 to the DCS. Administrator stated there was no physical assessment of Resident 133 regarding the allegations of abuse completed on 11/6/25, and there was no investigation into the allegations of abuse initiated on 11/6/25. Administrator stated CNA 5 was not removed from Resident 133's care immediately after allegations were made on 11/6/25. Administrator stated CNA 5 continued to provide care to Resident 133 (approximately 6 hours) after the allegations were made.During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect & Exploitation Policy, revised 10/22, the P&P indicated, [Facility's name] is committed to maintaining a safe environment for residents, visitors and associates. 1. Protection of Resident. Upon learning of alleged abuse . the Administrator or supervisor on duty should attempt to take necessary steps to verify residents are protected from subsequent episodes of abuse . If an allegation of abuse .is made against an associate or associates, the accused individuals should be suspended until the matter has been investigated and determination made as to the underlying allegation. ii. Follow up with reporting of the incident to the supervisor/manager on duty or Executive Director as soon as possible. 2. Provision of Medical Attention. Persons who are harmed during an incident should be provided medical attention, as appropriate. F. Investigation of Potential Abuse . 1. Internal Investigation. Upon receipt of resident abuse . the Administrator or designee should conduct a confidential internal investigation of the incident. a. The investigation should include interviews with potential witnesses, which may include the alleged perpetrator, the alleged victim, associates, other residents and visitors to the community. 3. Timing of Investigation. The investigation should be initiated as soon as practicable upon becoming aware of an incident. H. Internal Reporting . 2. Upon receiving reports of physical or sexual abuse, a licensed nurse or physician should immediately examine the resident. Findings of the examination should be recorded in the resident's medical record.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the temperature was taken for a cup of soup prior to serving it to one of three sampled residents (Resident 1) after being heated up, by the nursing staff, in the microwave. This failure resulted in Resident 1 sustaining a second degree burn (damages the epidermis (surface of the skin)) and dermis (thick layer of living tissue below the epidermis containing blood vessels, nerve endings, sweat glands, hair follicles and other structures) layers of the skin and is characterized by blistering, deep redness, swelling, and intense pain) to his left-hand pointer finger. Findings:During a review of Resident 81's admission Record (AR), the AR indicated Resident 81 was admitted on [DATE] and had diagnoses of acquired absence (loss of a body part) of right finger(s), polyneuropathy (damages many nerves in the body, causing a combination of symptoms like numbness, tingling, pain and muscle weakness), and rheumatoid arthritis (disease causing joint redness, swelling, and pain).During a review of Resident 81's Nursing readmission Data Collection (NRDC) dated 11/2/25, the NRDC indicated, Hot liquids safety.contractures (shortening and hardening of muscles, tendons, or other tissue, often leading to restricted joint mobility) in fingers, hands, wrists, elbows or shoulders.yes.weakness and/or paresis (muscular weakness caused by nerve damage or disease) in upper extremities.yes.loss of mobility/reduced movement in upper extremities.yes.risk determination.yes, the resident is at risk.care planning.the resident is at risk for hot liquid injury.assist resident with hot liquids.resident to use cup with lid. During a review of Resident 81's Minimum Data Set (MDS-resident assessment tool) dated 11/8/25, the MDS indicated, Brief Interview for Mental Status (BIMS).14 (indicating Resident 81 was cognitively intact (normal thinking, reasoning and processing of information)) .Functional Abilities.Functional Limitation in Range of Motion.Upper Extremity.2 (Impairment on both sides). During a review of Resident 1's Change in Condition (COC) dated 11/15/25, the COC indicated, burn to L (left) pointer finger.11/15/25.resident stated that they (Resident 81) were checking on instant soup and wanted to see if it was hot enough so they put their L pointer finger into the bowl, resident stated that due to neuropathy they were unable to tell if it was hot or not due to low sensation, when seeing therapy walk into room resident requested for therapist to call this writing nurse due to having open skin, upon observation skin around left pointer finger from first knuckle up and around nail has been removed, NP (nurse practitioner) & wife made aware.During a review of Resident 81's Wound Evaluation & Management Summary (WEMS) dated 11/20/25, the WEMS indicated, Patient has a history of neuropathy with very limited sensation to his fingers. Patient noticed he dipped his finger into something hot. Noted. he shouldn't have done that. This led to a wound to the tip of his first finger left hand. With the wound we did take off the fingernail the wound should go onto heel [sic] just fine.non-pressure wound of the left, first finger full thickness (a wound that extends through all layers of the skin).trauma/injury. wound size (L (length) x W (width) x D (depth)) 2 x 2 x 0.2 cm (centimeters-unit of measurement)During a review of Resident 81's Progress Note (PN) dated 11/20/25, the PN indicated, Patient has a history of neuropathy to his hands and feet. He noted that he dipped his index finger left hand into a cup of hot soup, he didn't notice that he had dipped it in there. Subsequently he developed a 2nd degree burn/deep 2nd with blistering around his fingernail, at the time we saw the patient we debrided (remove damaged tissue) the blister as the fingernail leaving am [sic] area to the lateral (side) aspect of his finger which still showed evidence of deep tissue injury.During an interview on 12/2/25 at 10:55 a.m. with Administrator, Administrator stated Resident 81 received a burn to his left-hand pointer finger when Certified Nursing Assistant 7 heated up his instant cup of noodle soup in the microwave and Resident 81 stuck his finger in the soup. Administrator stated per facility policy the temperature should have been taken before it was served to Resident 81 and it was not.During a concurrent observation and interview on 12/2/25 at 11:45 a.m. with Resident 81, in Resident 81's room, Resident 81 had Band-Aids wrapped around his left pointer finger. Resident 81 stated when staff heated up his instant cup of noodle soup, the cup was filled up above the water line and he stuck his finger in it and it burned his finger. Resident 81 stated the soup was heated up in the microwave. During an interview on 12/2/25 at 6:32 p.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated she was assigned to Resident 81 when PT reported that Resident 81's finger was red. LVN 5 stated CNA 7 heated up Resident 81's instant cup of noodle soup in the microwave and Resident 81 stuck his finger in the cup and burned his finger. LVN 5 stated CNA 7 did not take the temperature of the soup prior to giving it to Resident 81.During an interview on 12/2/25 at 6:45 p.m. with CNA 7, CNA 7 stated she heated up