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	12/08/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free from physical abuse (any intentional act causing injury or trauma to another person through bodily contact) when Certified Nursing Assistant (CNA) 1 hit Resident 1 on the right side of his face while CNA 1 and CNA 2 were changing Resident 1's adult brief. This failure resulted in Resident 1 crying and having redness on his face.Findings:During a review of the SOC-341 (Report of Suspected Dependent Adult/Elder Abuse), dated 8/26/25, the SOC-341 indicated, A CNA (2) stated another CNA (1) slapped a resident (Resident 1) in the face while providing care.During a review of Resident 1's Summary of the Incident (SI), documented by Administrator, dated 8/31/25, the SI indicated, 08/26/25 0540 (approximately) . (CNA 2) and (CNA 1) entered (Resident 1's) room and attempted to change (Resident 1). (CNA 2) was positioned on the right side of (Resident 1's) bed (closer to the room door) and (CNA 1) was positioned on the left side of (Resident 1's) bed (next to the window). (Resident 1) began hitting (CNA 2) and (CNA 1), and then (Resident 1) grabbed (CNA 1's) hands. (CNA 1) was able to pull her hands away from (Resident 1's) grip with (Resident 1) scratching (CNA 1's) right forearm. (CNA 1) looked down at her hand and hit (Resident 1) on the right side of his face with (CNA 1's) opened, left hand. Conclusion: Based on interviews and investigation the allegation (CNA 1 hitting Resident 1 on the right side of his face) is verified.During a review of Resident 1's admission Record (AR), dated 8/31/25, the AR indicated, DIAGNOSIS. ALZHEIMER'S DISEASE (loss of ability to think, remember, and reason effectively) . MAJOR DEPRESSIVE DISORDER (mood disorder [mental health condition that primarily affects a person's emotional state] that causes a persistent feeling of sadness and loss of interest) . LEGAL BLINDNESS (impaired ability to see objects clearly).During a review of Resident 1's Quarterly Minimum Data Set (MDS - an assessment tool), dated 6/17/25, the MDS indicated on Section C (Brief Interview for Mental Status), Resident 1 had a score of 3 (severely impaired cognition [difficulty remembering things, concentrating, making decisions and solving problems]). The MDS indicated on Section GG (Functional Abilities - capacity of an individual to perform tasks), Resident 1 waswheelchair bound (person requiring a wheelchair to get around). The MDS indicated, Resident 1 required substantial or maximal assistance (staff lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene (ability to maintain perineal hygiene [cleaning of the area between the anus and the genitals], adjust clothes before and after voiding [urinating] or having a bowel movement). The MDS indicated, Resident 1 required partial or moderate assistance (staff lifts, holds, or supports trunk or limbs, but provides less than half the effort) with rolling left and right on bed. The MDS indicated Resident 1 was unable to walk.During a review of Resident 1's Documentation Survey Report (DSR - ADL [Activities of Daily Living - basic self-care tasks needed to live independently] flowsheet), dated August 2025, the DSR indicated, on 8/25/25 night shift (10 p.m. to 6 p.m.), CNA 2 documented Resident 1 had no behavior symptoms.During a review of Resident 1's Care Plan (CP - personalized, written document that outlines an individual's specific health conditions, needs, goals, and preferences), initiated 5/24/24 and revised on 8/30/25, the CP indicated, (Resident 1) is/has episodes to demonstrate physical behaviors (swinging at staff when assisting with ADL function) r/t (related to) Alzheimer's disease. Interventions (any treatment or action that staff perform to enhance resident outcomes) . Provide physical and verbal cues to alleviate anxiety (feeling of worry); give positive feedback (to appreciate certain acts or behaviors), encourage to verbalize source of agitation (feeling of irritability, mental distress or restlessness).During a review of Resident 1's Change in Condition Evaluation (CCE), documented by Licensed Vocational Nurse (LVN) 1 on 8/26/25 at 7:14 a.m., dated 8/26/25, the CCE indicated, (LVN 1) were called from the office around 6:05 am regarding an allegation of a witnessed of physical abuse with the resident (1) and a CNA (1) involved. MD (Medical Doctor) was notified; on Neuro check (evaluates brain and nervous system [network of nerve cells and fibers that transmits nerve impulses between parts of the body] functioning) per policy and monitoring for any skin changes and psychosocial (mental and emotional state) changes. The CCE indicated there were no injuries noted on Resident 1.During an interview on 9/9/25 at 4:08 p.m. with Executive Director (ED), ED stated, (CNA 1) was interviewed three of four times, (CNA 1) did admit to the incident (CNA 1 hitting Resident 1 on the right side of his face on 8/26/25 at around 5:40 a.m.). ED stated the physical abuse incident (CNA 1 hitting Resident 1 on the right side of his face on 8/26/25 at around 5:40 a.m.) was substantiated (verified with investigation, and CNA 1 and CNA 2 interviews) on 8/31/25.During an interview on 10/8/25 at 2:45 p.m. with CNA 1, CNA 1 stated on 8/26/25 at around 5:45 a.m., CNA 1 was helping CNA 2 (CNA assigned to