

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 03/02/2026
NAME OF PROVIDER OR SUPPLIER Bayshire Riverwalk Post-Acute		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 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:1. Follow the physical therapy (type of treatment that helps regain normal movement and ease pain after an injury, surgery, or a medical condition that limits the ability to function) recommendation for non-weight bearing status (limiting the amount of weight or pressure placed on a specific limb) on right upper extremity (RUE) for one of three sampled residents (Resident 1) when Certified Nursing Assistant (CNA 1) instructed Resident 1 to hold onto the grab bars with both hands while in the shower room.2. Ensure Resident 1 was sitting in the shower chair while being undressed in the shower room for one of three sampled residents (Resident 1).3. Ensure Resident 1 was standing on a dry non-slippery floor in the shower room for one of three sampled residents (Resident 1).These failures resulted in Resident 1 slipping and falling on wet shower floor, which resulted in two skin tears (traumatic wound where the top layer of skin separates from the lower layer) and bruising to left forearm (part of the arm extending from the elbow to the wrist of the fingertips), bump on the back of the head, pain on the head, left forearm and left knee, and was sent to the acute hospital for evaluation and treatment, and resulted in Resident 1 experiencing nervousness (temporary feeling of worry, often triggered by stressful situations) about showers.Findings:During a review of Resident 1's admission Record (AR), dated 12/8/25, the AR indicated, DIAGNOSIS (admission). FRACTURE (broken bone) OF ONE RIB (curved bone in the chest that form a cage to protect the heart and lungs), LEFT SIDE. COMPLETE ROTATOR CUFF TEAR (one of the shoulder tendons [bands that attach shoulder muscles to the arm bone] has detached entirely from the arm bone) OR RUPTURE (sudden, violent break or tear) OF RIGHT SHOULDER. MUSCLE WEAKNESS (GENERALIZED). ABNORMALITIES OF GAIT (walking pattern) AND MOBILITY. HISTORY OF FALLING.During a review of Resident 1's Minimum Data Set (MDS - an assessment tool), dated 12/14/25, the MDS indicated in Section C (Cognitive Patterns), Resident 1 had a BIMS (Brief Interview for Mental Status) score of 14 (score of 13-15 means cognitively intact [clear, functioning mental abilities). The MDS indicated in Section GG (Functional Abilities), Resident 1 had a functional limitation in range of motion (full, normal distance and direction a joint can move) on one side of her upper extremity (shoulder, elbow, wrist, hand), Resident 1 was dependent (helper does all of the effort) with lower body dressing (the ability to dress and undress below the waist), and Resident 1 required partial or moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with sit to stand (the ability to come to a standing position from sitting).During a review of Resident 1's Order Details (OD) (admission Order), dated 12/8/25, the OD indicated, Keep sling (fabric support used to hold an injured arm, shoulder, or collarbone in a stable, resting position) on 24 hrs (hours) on R (right) Arm (due to admitting diagnosis of Complete Rotator Cuff Tear or Rupture of Right Shoulder on 12/8/25).During a review of Resident 1's Visual/Bedside Kardex Report (VBKR - special instructions for nursing staff pertaining to resident's care), dated 12/9/25, the VBKR indicated, Special Instructions. Follow MD (medical doctor) orders for weight bearing status. Non-weight bearing (injured limb must not touch the ground or support any body weight) to R (right) upper extremity.During a review of Resident 1's PT (Physical Therapy) Evaluation (continued on next page)</p>		

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 0689 Level of Harm - Actual harm Residents Affected - Few	<p>& Plan of Treatment (PTEPT), dated 12/9/25, the PTEPT indicated, R shoulder fx (fracture). (Resident 1) is a fall risk, NWB (non-weight bearing) on R UE (upper extremity), R arm sling. During a review of Resident 1's Nursing admission Data Collection (NADC), dated 12/8/25, the NADC indicated, Resident 1 had a fall risk score of 16 (score of 10 or higher indicates high risk for falls). During a review of Resident 1's Care Plan (CP - written, individualized document detailing a resident's health conditions, specific needs, and the tailored actions or services required to manage them), dated 12/9/26 (date initiated), the CP indicated, Focus. (Resident 1) has alteration in musculoskeletal (human body system that provides the body with movement, stability, shape, and support) status r/t (related to) . R shoulder rotator cuff injury with R sling at all times. Interventions. Follow MD (medical doctor) orders for weight bearing status. During a review of Resident 1's CP, dated 1/5/26 (date initiated), the CP indicated, Focus. (Resident 1) is at risk for falls r/t h/o (history of) falling (at home), decrease mobility. Interventions. The resident (1) needs prompt response to all requests for assistance. PT evaluate and treat as ordered. During a review of Resident 1's Change in Condition Evaluation (CCE), dated 1/15/26 (date of fall incident at the facility), the CCE indicated, (Resident 1) had a fall in the shower room with CNA (1). (Resident 1) stated she slipped on the wet floor, hit her head hard on the wall, skin tear on her left forearm with moderate bleeding (no measurement indicated). Able to move all extremities except right arm d/t (due to) previous shoulder injury. CNA (1) stated (Resident 1) stood up but (Resident 1) was focused on removing (Resident 1's) pants by herself, slipped, lost her footing and had a fall. (Resident 1) complain of pain on head [sic] and left forearm. Hall (ambulance) was called, pain med (medication) administered. Arm wrapped. Skin Status Evaluation. bump on the back of the head. left forearm skin tear. During a review of Resident 1's Medication Administration Record (MAR), dated January 2026, the MAR indicated, Resident 1 complained of 6/ (over) 10 pain (pain level of 4-6 means moderate pain) (no location indicated) on 1/15/26 at 12:39 p.m. (date and time of fall incident) and was administered Oxycodone-Acetaminophen (pain medication) tablet 5-325 mg (milligrams [unit of mass]). During a review of Resident 1's Emergency Documentation (ED) (Acute Hospital), dated 1/15/26, the ED indicated, Chief Complaint ED: Fall 01/15/26. (Resident 1) presents following fall and Head injury, skin tear. (Resident 1) states she had a mechanical fall (fall caused by an outside force such as tripping, slipping, or stumbling) in the shower while (Resident 1) was being held by a new CNA (1). Complaining of left knee pain and she does have a skin tear to the left forearm. Impression and Plan. Acute (condition or symptoms of sudden onset) head injury. Blunt trauma (physical injury caused by non-penetrating impact). Fall. Fracture of humeral (relating to the region of the humerus or shoulder) head, right. Skin tear of upper extremity. discharged . 01/15/2026. During a review of Resident 1's Nursing Progress Note (NPN), dated 1/15/26, the NPN indicated, (Resident 1) came back to the facility at this time. noted the skin tear (no measurement indicated) with bruise (no measurement indicated) on (Resident 1's) left arm around elbow and forearm, also c/o (complained of) pain, medication given to help manage the pain (no location indicated). During a review of Resident 1's IDT (Interdisciplinary Team - a collaborative group working together to deliver integrated, patient-centered care) Post Event Analysis (IDTPEA), dated 1/16/26, the IDTPEA indicated, Date and time of the fall: 01/15/2026 . (Resident 1) had a fall in the shower room with CNA (1). (Resident 1) stated she slipped on the wet floor, hit her head hard on the wall (CNA [1] stated [Resident 1] hit her head on the grab bar) two skin tears on her left arm with moderate bleeding (no measurement indicated). Able to move all extremities except right arm d/t (due to) previous shoulder/neck injury. CNA (1) stated she stood up but (Resident 1) was focused on removing her pants by herself, slipped on the water, tangled her foot on her pant legs as she was trying to take them off and lost her footing and had a fall. (Resident 1) complain of pain on head [sic] and left forearm. Pain med (medication) administered and arm wrapped. (Resident 1) transferred to ER (Emergency Room) for evaluation. What was the resident's apparel at the time of the event? . Bare feet. CNA (1) states the resident (1) was holding the grab bars with both hands. Resident (1) is non weight bearing to the right hand. NEW Interventions put in place (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>after event to prevent recurrence. Reeducate CNAs on having shower floor free from water from prior showers and having residents sit while undressing. During a review of Resident 1's VBKR, dated 1/16/26, the VBKR indicated, Special Instructions. SAFETY. Re-educate CNA having shower floor free from water from previous shower. High Fall Risk. During a review of Resident 1's Social Services Progress Note (SSPN), dated 1/16/26, the SSPN indicated, SSD (Social Services Director) went to visit with Resident 1) due to nervousness and fear after fall. (Resident 1) stated that she fell in the shower. (Resident 1) stated that she is a little nervous about showers, therapy, and ADL's (activities of daily living [routine self-care tasks such as bathing, dressing, eating, toileting, and moving around]). (Resident 1) stated that she does not want to have another fall. During a review of Resident 1's VBKR, dated 1/27/26, the VBKR indicated, Special Instructions. SAFETY. Re-educate CNA having resident sitting while undressing. During a review of Resident 1's VBKR, dated 2/11/26, the VBKR indicated, Special Instructions. Bathing. Two associates at a time when offering shower. SAFETY. Re-educate CNA having shower floor free from water from previous shower and resident sitting while undressing. During an interview on 2/6/26 at 2:55 p.m. with Director of Nursing (DON), DON stated Resident 1 had a fall on 1/15/26 in the shower room. DON stated Resident 1 was with CNA 1 in the shower room, Resident 1 was standing up holding onto the grab bar, CNA 1 was helping Resident 1 get her pants down, Resident 1 let go of the bar and tried to get her left leg out of the pants that got tangled into her pants. DON stated the floor was a little bit wet so CNA 1 instructed Resident 1 to hold onto the grab bar with both hands, but Resident 1 lost her balance and fell backwards. DON stated Resident 1 bumped her head on the grab bar, landed on the floor pretty hard, got two large skin tears and was sent to the hospital. DON stated the shower floor was wet because there was a resident who previously showered in there. During an interview on 2/6/26 at 3:59 p.m. with DON, DON stated, It (Resident 1's fall on 1/15/26) could have been (prevented), unfortunately, it didn't. During a concurrent observation and interview on 2/6/26 at 4:11 p.m. with Resident 1 in Resident 1's room, Resident 1 was sitting on her wheelchair. Resident 1 stated prior admission to the facility, she had a fall incident in her apartment and sustained multiple fractures. Resident 1 stated she was admitted to the facility with a right shoulder fracture, had to wear a sling on her right arm, and could not use or bear weight on her right arm. Resident 1 stated on 1/15/26, she had a fall incident when she was in the shower room with CNA 1. Resident 1 stated while she was standing, CNA 1 pulled her pajamas down and while she was standing, CNA 1 stepped away and that was when she fell on the floor. Resident 1 stated she hit the right back side of her head on the wall causing Resident 1 to have a bruise and a bump on her head, and Resident 1 hit her left arm on the floor tile and cut her left elbow. Resident 1 stated she slipped because the shower floor was wet and slippery and Resident 1 was bare feet. Resident 1 stated the water was on when CNA 1 was undressing her in the shower room. Resident 1 stated on 1/15/26, she was not really able to stand without help. Resident 1 stated after her fall incident on 1/15/26, she developed a fear of falling again in the shower and she was feeling nervous about showers. During an interview on 2/9/26 at 12:15 p.m. with CNA 1, CNA 1 stated before CNA 1 took Resident 1 to the shower room on 1/15/26 around 11:30 a.m. Resident 1 was wearing a sling on one of her arms (right arm) and Resident 1 had difficulty moving one of her arms (right arm). CNA 1 stated she did not know if Resident 1 had any weight bearing restrictions on the upper extremities. CNA 1 stated (1/15/26) when she was transferring Resident 1 from the wheelchair to the shower chair, CNA 1 instructed Resident 1 to hold onto the grab bar with both hands while standing. CNA 1 stated the shower floor was a little wet. CNA 1 stated, It (water) could have been on (the shower head was pointing at the wall, with water dripping on the floor). CNA 1 stated she would usually turn on the water and wait for the water to get warm while she undresses the residents in the shower room. CNA 1 stated Resident 1 was trying to get her pants off one of her ankles while she was standing and fell. CNA 1 stated she should have wiped the shower floor dry to prevent Resident 1 from falling. CNA 1 stated she should have had Resident 1 sit down before taking off Resident 1's pants to prevent Resident 1's feet from getting stuck in the pants and Resident 1 losing her balance. (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>CNA 1 stated she should have asked the nurse about Resident 1's weight bearing restrictions on the upper extremities before taking Resident 1 to the shower room on 1/15/26. During a concurrent interview and record review on 2/10/26 at 12:53 p.m. with Physical Therapist Assistant (PTA), Resident 1's Occupational Therapy Treatment Encounter Note ([NAME]), dated 1/15/26, was reviewed. The [NAME] indicated, NWB on RUE. PTA stated Resident 1 was non-weight bearing on her right upper extremity and can only use her left arm (non-affected side) to hold onto the grab bar in the shower. PTA stated Resident 1's fracture could have delayed healing or could get worse if the staff would go against the non-weight bearing restriction for Resident 1. PTA stated CNA 1 should have asked the nurse or therapy department about Resident 1's weight bearing restrictions on the upper extremities. During an interview on 2/17/26 at 2:34 p.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated he was the nurse assigned to Resident 1 when she had a fall incident on 1/15/26. LVN 1 stated he was in the nurse's station across the shower room, and CNA 1 called him into the shower room when Resident 1 fell. LVN 1 stated he saw Resident 1 on the floor with no shirt on, and her pants and briefs were partly taken off. LVN 1 stated Resident 1 stated she had slipped in the shower and Resident 1 hit her head on the wall. LVN 1 stated he assessed Resident 1 and noted a bump on her head (no measurement given), two left forearm skin tears (one measured an inch [site 1] and the other one was five centimeters [site 2]), purple discoloration (no measurement given) around Resident 1's left forearm, and limited range of motion on Resident 1's right upper extremity. LVN 1 stated after the fall incident, Resident 1 complained of pain (head and left forearm) and was given pain medication. LVN 1 stated after the fall incident, Resident 1 was crying. During an interview on 2/18/26 at 8:50 a.m. with Social Services Director (SSD), SSD stated during her psychosocial (refers to how one's individual thoughts, emotions, and behaviors are influenced by their social environment) visit on 1/16/26 with Resident 1, Resident 1 verbalized feeling a little nervous about showers, therapy and ADLs. During an interview on 2/18/26 at 9:10 a.m. with DON, DON stated to address Resident 1's feeling of nervousness about showers, the facility had let Resident 1 know she can have a bed bath, and the facility would have two associates be with Resident 1 to support her during a bed bath or a shower. During an interview on 2/18/26 at 10:05 a.m. with Family Member (FM) 1, FM 1 stated he was visiting Resident 1 on 1/15/26 (date of fall incident). FM 1 stated the facility staff called him into the shower room where Resident 1 was, FM 1 saw Resident 1 laying on the wet floor sobbing (intense, loud crying), there were no towels on the floor, Resident 1 had her pants down below her knees, was bare feet, and Resident 1's lower extremities (part of the body that includes the hip, thigh, knee, ankle, and foot) were wet. During an interview on 2/18/26 at 1:45 p.m. with DON, DON stated Resident 1 was non-weight bearing on her RUE on 1/15/26 (date of fall incident). DON stated on 1/15/26 in the shower room, CNA 1 asked Resident 1 to briefly stand to partially take Resident 1's pants off. DON stated it is the facility's common practice for all the CNAs to undress the residents in the shower room on the shower chair. During a review of the facility's P&P titled, Falls Management Policy, dated October 2025, the P&P indicated, Residents should be evaluated for the risk of falling so that interventions may be considered in order to: Promote resident safety Promote appropriate clinical and interdisciplinary assessment of falls and fall risk factors Coordinate management of acute and recurrent falls. Resident Centered Approaches. Initial interventions may include, but are not limited to room set up, reviewing the resident's balance, footwear review, lighting, call system orientation, personal items within reach, etc. (et cetera [and similar things]). If a fall occurs with interventions in place, IDT should review the resident to determine if additional or different interventions should be implemented.</p>		