

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/04/2025
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.			
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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. **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 (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 0689 Level of Harm - Actual harm Residents Affected - Few	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 Resident 81's instant cup of noodle soup in the microwave for 1 1/2 minutes. CNA 7 stated she did not take the temperature of the soup prior to giving it to Resident 81. During an interview on 12/3/25 at 4:23 p.m. with Physical Therapist (PT), PT stated when he entered Resident 81's room on 11/15/25, Resident 81 was biting on his left pointer finger and covering up blood that was on his finger. PT stated from the top knuckle to the fingertip Resident 81's finger was red. PT stated Resident 81 was burned by a cup of hot noodles and was not aware of the burn due to decreased sensation in his fingertips. During an interview on 12/3/25 at 4:47 p.m. with Registered Dietician (RD), RD stated when heating up the instant cup of noodle soup for Resident 81 the CNA heated up the soup in the microwave and did not take the temperature prior to serving it to Resident 81. RD stated the CNAs were allowed to heat up the resident's food in the microwave at the time of the incident but had not received training on taking the temperatures prior to serving. RD stated Resident 81 wanted to test the temperature of the soup himself and used his finger like a stir stick and did not feel the burning. RD stated the temperature should have been taken prior to serving the soup to Resident 81 for safe consumption. During a review of the facility's policy and procedure (P&P) titled, Safety of Hot Liquids dated 02/2020, the P&P indicated, The potential for burns from hot liquids is considered an ongoing concern among residents with weakened motor skills, balance issues, impaired cognition (mental action of acquiring knowledge and understanding through thought, experience, and the senses) and nerve or musculoskeletal conditions. Food service associates shall monitor and maintain foods temperatures that comply with food safety requirements but do not exceed recommended temperatures to prevent scalding. During a review of the facility's policy and procedure (P&P) titled, Food and Beverage Temperature Control dated 12/24, the P&P indicated, To ensure the safety of resident and associates, it is critical that all potentially hazardous food and beverages be prepared and maintained at safe temperatures. All foods should be cooked to the minimum safe internal cooking temperatures as outlined. Use the food and beverage temperature log to ensure all food and beverage holding temperatures are monitored and recorded. Food temperature chart. soups. 140-165 F (Fahrenheit-unit of measurement used to measure temperature). Food code temperatures. food cooked in microwave oven. temperature 165 F. hold covered for 2 minutes after removing.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals (a therapeutic substance, such as a vaccine or drug, derived from biological sources) were stored appropriately when: 1. Vaccines were not labeled after opening. 2. Expired medications were not disposed. These failures had the potential to result in residents being administered vaccines and medications that were expired and not receiving the intended therapeutic effect. Findings: 1. During a concurrent observation and interview on 12/2/25, at 11:39 a.m. with Licensed Vocational Nurse (LVN) 1, in Medication Room (2), a vial of (Tubersol (TB) is an infection that usually affects the lungs) for (Tuberculin skin tests (TST) are administered to detect the presence of Mycobacterium (type of germs) tuberculosis, the bacterium that causes TB) was opened with no open date. LVN 1 stated the vial should have been dated when opened. During a review of the facilities Immunization Report (IR) (undated), the IR indicated, the following TST's were administered to residents on 11/4/25, 11/8/25, 11/12/25, 11/13/25, 11/14/25, 11/16/25, 11/17/25, 11/18/25, 11/20/25, 11/21/25, 11/22/25, 11/23/25, 11/24/25, 11/25/25, 11/26/25, 11/28/25, and 11/30/25. 2. During a concurrent observation and interview on 12/3/25, at 10:22 a.m. with LVN 2, at Medication Cart 2, Lispro Insulin (fast acting insulin for high blood sugars within the blood) was opened and was not labeled with a residents name and opened date. LVN 2 stated the medication should have been removed from the cart and discarded. During a concurrent observation and interview on 12/3/25, at 10:23 a.m. with LVN 2, at Medication Cart 2, a bottle of zinc (mineral) 50 mg (milligrams) expired on 11/2025. LVN 2 stated the bottle of Zinc should have been removed and discarded. During a review of the facility's policy and procedure (P&P) titled, Storage and Expiration Dating of Medications and Biologicals, dated 12/1/07, the P&P indicated, 10. Facility should ensure medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacture or supplier guidelines. 11. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for open medications. Facility staff should record the date opened on the primary medication container. once opened. 11.3 If a multi-dose vial of an injectable medication has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure professional standards for food service safety and sanitary kitchen conditions were followed when: 1a. Dry food items were not stored in airtight sealed containers.1b. Vegetables were retained that were not safe for consumption.1c. Cold food items were not covered to prevent spillage and cross-contamination.2a. Clean dishware was not covered to prevent debris contamination.2b. Clean Utensils were not covered to prevent contamination.3a. Pasta was not labeled with an opened date.3b. Dairy Creamer was not labeled with an opened date.3c. Individually pre-dished, cut-up fruit, vegetables, and baked desserts were not labeled with prepared and use-by dates.These failures had the potential to cause foodborne illnesses (illness caused by the ingestion of contaminated food or beverages) for residents.Findings:1a. During a concurrent observation and interview on 12/1/25 at 9:21 a.m. with Certified Dietary Manager (CDM), in the dry storage room the following was found:An opened 25-pound (measurement of weight) bag of long-grain brown rice.An opened 5-pound bag of macaroni pasta.An opened 10-pound bag of penne pasta.An opened 5-pound bag of curly medium egg noodle pasta.CDM stated the long-grain brown rice, macaroni, penne, and egg noodle pastas should be stored in containers with lids and sealed to prevent debris and bugs potentially getting in.1b. During a concurrent observation and interview on 12/1/25 at 9:42 a.m. with CDM, in the refrigerated storage room, the following was found:Two cucumbers with diffuse, dark, black, and fuzzy white spots were inside a vegetable produce box. CDM stated the cucumbers were moldy, should not have been retained, and needed to be discarded.One tomato had the stem and core removed was inside a vegetable produce box. CDM stated when tomatoes are prepped for use, they are washed and cored. CDM stated the cored tomato should not have been placed back into the vegetable produce box with unwashed produce.During an interview on 12/2/25 at 10:30 a.m. with Server, Server stated produce like vegetables and fruits were to be checked for freshness. Server stated when a tomato is prepared, it is washed and cored before use. Server stated a prepared cored tomato should not be placed back into the produce storage box with unwashed produce.1c. During a concurrent observation and interview on 12/1/25 at 9:39 a.m. with CDM, in the refrigerated storage room, the snack, drinks, and refreshment cart had applesauce with an open lid that spilled contents onto other items on the cart. CDM stated there were 15 juices, 4 milks, 6 fruit cups, 4 yogurts, and 3 apple sauce containers. CDM stated there was an open applesauce container that had spilled onto other drink and snack items. CDM stated the drink and refreshments were contaminated and should have been discarded.During a review of the facility's policy and procedure (P&P) titled, FOOD STORAGE, dated 9/14/2018, the P&P indicated, POLICY. Food items should be stored . in accordance with good sanitary practice. PROCEDURE. Remember to cover, label and date. Dry Storage. 7. Any opened products should be placed in seamless plastic or glass containers with tight-fitting lids. Fresh Vegetables 1. Fresh vegetables should be checked and sorted for ripeness. 3. Unwashed produce should not be placed in the refrigerator with or near prepared foods due to high levels of competing organisms [germs].During a review of the facility's P&P titled, Storage of Perishable Food, dated 5/10, the P&P indicated, Perishable food must be refrigerated in a manner to optimize food safety, nutrient retention and aesthetic quality. Perishable foods include: fruits, vegetables, meats, dairy etc. 5. All pre-dished items must be covered, labeled, and dated to prevent off-flavors, drying, or cross-contamination while refrigerated.2a. During a concurrent observation and interview on 12/1/25 at 9:28 a.m. with CDM, in the dry storage room, glass dishware bowls were stored uncovered and inside surface area upright with debris. CDM stated she did not know what the debris was inside the glass bowl dishware. CDM stated the glass bowl dishware should be covered and stored with the inside surface area faced down.During a review of the facility's P&P titled, DISH AND UTENSIL PROCEDURE, dated 3/3/20, the P&P indicated, 2. Cups, glasses, bowls, and plates shall be handled without contact with inside (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surfaces or surfaces that contact the user's mouth . 9. Any dish, tray or utensil with debris should not be used.2b. During a concurrent observation and interview on 12/1/25 at 9:30 a.m. with CDM, in the dry storage room, adaptive (built-up silverware for residents, such as larger handles and gripping) utensils were inside an uncovered bin. CDM stated the bin should have a lid to prevent debris and bugs from contaminating the clean utensils. CDM stated when the container lid is opened, there was a chance of contamination and was an infection control concern.During a review of the facility's P&P titled, DRY STORAGE - DISHES AND UTENSILS, dated 2/1/12, the P&P indicated, Enclosed storage should be provided for clean and sanitized dishes and utensils. PROCEDURE 1. Spoon, knives, and forks shall be stored in containers with the handles upward or shall be covered.3a. During a concurrent observation and interview on 12/1/25 at 9:21 a.m. with CDM, in the dry storage room, the following was found:An opened 25-pound (measurement of weight) bag of long-grain brown rice.An opened 5-pound bag of macaroni pasta.An opened 10-pound bag of penne pasta.An opened 5-pound bag of curly medium egg noodle pasta.CDM stated the long-grain brown rice, macaroni, penne, and egg noodle pasta should have been labeled with open dates.3b. During a concurrent observation and interview on 12/1/25 at 9:34 a.m. with CDM, in the refrigerated storage room, an opened two-quart (unit of measurement) container of dairy creamer did not have an opened date label. CDM stated the dairy creamer should be labeled with an opened date to ensure food quality and safety.3c. During a concurrent observation and interview on 12/1/25 at 9:48 a.m. with CDM, in the refrigerated storage room, two trays of 4-ounce pre-dished, cut-up fruit, vegetables, and baked dessert were not labeled with prepared and use-by dates. CDM stated the two trays of pre-dished desserts, which included watermelon (quantity 7), sugar-free pound cake (quantity 6), and cucumber salad (quantity 9), were expected to be labeled with preparation and use-by dates.During a review of the facility's P&P titled, USE-BY DATES ON REFRIGERATED ITEMS, dated 10/17/22, the P&P indicated, Labeling & Dating Standards. All products should be dated upon receipt. All items should be dated when opened. Enter Use-By dates on all food once opened and stored under refrigeration.During a review of the facility's P&P titled, Labeling, dated 9/24, the P&P indicated, All food items must be labeled and dated before storing. Policy Detail 1. Upon receipt from vendors, all non-perishable food items must be labeled with the received date (month and year) before putting in dry storage. 2. All prepared items must have a label with the name of item, date and time prepared, by whom, and discard/use by date. Discard/use by dates should be no more than 3 days for leftovers/hazardous foods and 7 days for all other prepared food.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement effective infection control practices when the facility failed to:1) Follow their policy and procedure (P&P) on Infection Prevention and Surveillance when the facility's Infection Control Surveillance (ICS) binder did not contain information on infection trend tracker, changes and resolution, analyzation of trends identified, and educational program based on prevention.2) Ensure three of three dirty linen containers were in good repair.3) Ensure floors were disinfected (cleaned with chemical to destroy bacteria which causes diseases).4) Follow their P&P titled, ISOLATION TRAYS for one of five sampled residents (Resident 128).5) Assist two of five sampled residents (Resident 37 and Resident 84) with hand hygiene. These failures had the potential to spread infection to residents, staff, and visitors. Findings: 1) During a concurrent interview and record review on 12/3/25 at 10:26 a.m. with Infection Prevention Nurse (IPN), the facility's ICS binder dated August 2025, September 2025, and October 2025 were reviewed. The facility's ICS binder did not contain information on infection trend tracker which included changes and resolutions and no analyzation of trends identified, educational programs based on prevention, trends and outcomes. IPN stated the tracking and trending was not in the infection surveillance binder. During a review of the facility P&P titled, Infection Prevention and Surveillance dated 1/2020, the P&P indicated, The Nurse Leader designee shall track, trend and monitor infections in an ongoing basis to assist with the prevention, development and transmission of disease and infection. Policy Details: A. Each resident shall be reviewed for infectious diseases upon admission and on an ongoing basis. B. Nurse Leader Designee: 1. Shall apply scientific principles and methods to determine if the infection meets the criteria. 2. Shall data enter infections into the Infection Trend Tracker. 3. Shall provide updates in the Infection Trend Tracker including changes and resolution. 4. Shall analyze trends identified, investigate outbreaks of infection and implement infection preventions. 6. Plans and coordinates educational programs and based on prevention, trends and outcomes, including benefits of immunization. C. Infection Prevention Risk Assessment: 2. Infection Prevention Risk Assessment spreadsheet to be completed at a minimum of annually and/or when there is a significant change in resident population. 2) During a concurrent observation and interview on 12/3/25 at 11:10 a.m. in the laundry room, with Housekeeping Lead (HL), there were three large yellow containers of dirty linens. The three yellow containers had rips on all edges, exposing the metal frames. HL stated the dirty linen containers needed to be replaced. During a review of the facility's P&P titled, Laundry and Bedding dated 9/2019, the P&P indicated, Place and transport contaminated laundry in bags or containers in accordance with established policies governing the handling and disposal of contaminated items. 3) During a concurrent observation and interview on 12/3/25 at 10:53 a.m. with Housekeeper (HK) 1, in the hallway, HK 1 was mopping the floor. There was a yellow bucket with liquid in it where she was rinsing her mop. When asked what was in the yellow bucket, HK 1 stated, It's [liquid] just plain water. When asked if the water contained disinfectants (a chemical liquid that destroys bacteria that can cause and spread of diseases), HK 1 stated no. HK 1 stated she used the same water to rinse the mop for three to four rooms before replacing the water. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/3/25 at 11:05 a.m. with HL, HL stated she was told by the management not to put any disinfectant into the water to mop the floors. HL stated, We don't disinfect the floors, we just mop with hot water. During an interview on 12/3/25 at 3:34 p.m. with Administrator, Administrator stated the water for mopping needs to be mixed with disinfecting liquid. During a review of the facility's P&P, titled Cleaning and Disinfection of Environmental Surfaces & Common Areas dated 7/2019, the P&P indicated, Non-critical items are those that come in contact with intact skin but not mucous membranes. Non-critical environmental surfaces include bed rails, some food utensils, bedside tables, furniture and floors. Non-critical surfaces will be disinfected with an EPA-registered intermediate or low-level hospital disinfectant according to the label's safety precautions and use directions. 4) During a concurrent observation and interview on 12/1/25 at 12:53 p.m. with Certified Nursing Assistant (CNA) 1, in the doorway of Resident 128's room, CNA 1 gathered Resident 128's dining plate warmer, cover, and a drinking cup partially filled with milk. CNA 1 stated she needed assistance removing Resident 128's dining tray contents because he was in contact isolation (transmission-based precaution, wearing personal protective equipment (PPE) gloves and a gown). During an observation on 12/1/25 at 12:59 p.m. in the doorway of Resident 128's room, CNA 1 was wearing soiled gloves, then handed CNA 2 Resident 128's meal tray's contents; plate warmer/cover, and a drinking cup partially filled with milk without changing her gloves or placing the meal tray contents inside of a plastic bag (barrier). CNA 2 was not wearing gloves, and there was no barrier between the contact isolation meal tray items and CNA 2's hands or body. During an interview on 12/1/25 at 1:02 p.m. with CNA 2, CNA 2 stated, We are not allowed to wear gloves in the hallway. CNA 2 stated she was unable to identify infection control prevention measures that could have prevented cross-contamination while she assisted in the removal of Resident 128's meal tray contents. During a review of Resident 128's Order Summary Report (OSR), dated 12/4/25, the OSR indicated, Contact isolation d/t [due to] ESBL [Extended Spectrum Beta Lactamase- bacteria (germs) infection]. During a concurrent observation and interview on 12/2/25 at 9:11 a.m. with CNA 3, in Resident 128's room, CNA 3 placed Resident 128's meal tray inside of a plastic bag. CNA 3 then handed the meal tray inside of the plastic bag to CNA 4 that was standing outside the room. CNA 3 stated the facility's process for removing meal trays and their contents from a contact isolation room included placing the items in a plastic bag, which served as a barrier between the contaminated items and the environment. CNA 3 stated this was an infection prevention measure to prevent cross-contamination. During an interview on 12/3/25 at 3:33 p.m. with IPN, IPN stated the facility's process of removing a meal tray from an isolation room was to place the tray in a plastic bag that serves as a barrier to prevent cross-contamination. IPN stated the facility staff were expected to maintain a barrier between themselves and items removed from a contact isolation room. IPN stated there was no P&P to provide for staff not to wear gloves in the hallway. IPN stated she was unaware of a P&P for the removal of meal trays from an isolation room. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Handwashing/Hand Hygiene, dated 10/2025, the P&P indicated, G. CDC recommends using Alcohol Based Hand Sanitizer. Unless hands are visibly soiled. 12. After contact with objects. in the immediate vicinity of the resident.J. Single-use disposable gloves should be used. 3. When in contact with a resident, or the equipment or environment of a resident, who is on contact precautions. During a concurrent interview and record review on 12/4/25 with IPN, the facility's P&P titled, ISOLATION TRAYS, dated 8/31/18 was reviewed. The P&P indicated, b) No special precautions are indicated unless these items are visibly contaminated with infective material (example: blood, drainage, secretions). c) If visibly contaminated with infective material, reusable dishes, utensils, and trays should be bagged and labeled before being returned to the food service department. IPN stated when Resident 128's meal tray items were removed from his room they should have been placed inside a plastic bag for transport back to the kitchen. IPN stated, There was a breach in the infection control process. 5) During a concurrent observation and interview on 12/1/25 at 12:55 p.m. with Resident 37 in Resident 37's room. CNA 2 placed the lunch tray on Resident 37's bedside table. Resident 37 was asked if she had been offered to have her hands washed or had been given a towelette to wipe her hands before she received her meal tray. Resident 37 stated she had not been offered to wash her hands before her tray was given. During an interview on 12/1/25 at 1:17 pm with Family Member (FM) 1, FM 1 stated she comes all week and she has not seen or heard of the staff offering to wash the residents hands. During a concurrent observation and interview on 12/1/25 at 1:18 p.m. with Resident 84, in Resident 84's room. CNA 2 placed the lunch tray on Resident 84's bedside table. Resident 84 was asked if she had been offered to have her hands washed or had been given a towelette to wipe her hands before she received her meal tray. Resident 84 stated she had not been offered to wash her hands before her tray was given. During an interview on 12/1/25 at 1:19 p.m. with CNA 2. CNA 2 stated she had given Resident 37 and Resident 84 their meal tray and had not offered them hand hygiene and stated she should have. During a review of the facility's P&P titled, Handwashing/Hand Hygiene, dated 10/25, the P&P indicated, This community considers hand hygiene the primary means to prevent the spread of infections.E. Residents, family members and/or visitors will be encouraged to practice hand hygiene. F. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations 1. When hands are visibly soiled. 2. Before eating.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to implement an effective antibiotic stewardship program (a systematic approach to educate and support health care professionals to follow evidence-based guidelines for prescribing and administering antibiotics/antimicrobials) for four of four sampled residents (Resident 10, Resident 134, Resident 135, and Resident 3). This failure had the potential for residents developing antibiotic resistance (bacteria evolve defenses, allowing them to survive drugs meant to kill them, making infections harder to treat, this happens when bacteria change due to antibiotic use, creating superbugs, leading to longer illnesses, higher costs, and increased mortality) with the use antibiotic and experiencing adverse health outcomes. Findings: During a concurrent interview and record review on 12/3/25 at 9:03 a.m. with Infection Prevention Nurse (IPN) and Interim Director of Nursing (IDON), the facility's Infection Control Surveillance (ICS) binder dated August 2025, September 2025, and October 2025 were reviewed. The ICS indicated Resident 10 had Vancomycin (strong antibiotic medication) 750 mg (milligram) for cellulitis (bacterial infection of skin, tissues, and muscles) on 3/15/25 and 3/19/25. IPN and IDON stated the ICS did not indicate Resident 10's laboratory results for the use of Vancomycin. ICS indicated Resident 134 had Zosyn (strong antibiotic medication) discontinued on 9/6/25. IPN and IDON were unable to provide information and documentation if Zosyn was appropriate for Resident 134. ICS indicated Resident 135 had Levaquin (antibiotic) for infection of the glut (muscles in the buttocks). IDON was unable to provide information and documentation for Resident 135's use of Levaquin. ICS indicated Resident 3 had Cipro (antibiotic for bladder infection) for Urinary Tract Infection (infection of the bladder). IDON stated the ICS did not have documented laboratory results of urinalysis (analysis of urine to test for the presence of disease) for Resident 3. There was no available information and infection trend tracker provided for Resident 10, Resident 134, Resident 135, and Resident 3's use of antibiotics. During a concurrent interview and record review on 12/3/25 at 10:26 a.m. with IPN, the facility's ICS binder dated August 2025, September 2025, and October 2025 was reviewed. There were no infection trend tracker which included changes and resolutions and no analyzation of trends identified. There were no educational programs based on prevention, trends and outcomes included in the binder. IPN stated the tracking and trending documentation was not in the infection surveillance binder. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship dated 9/2025, the P&P indicated, The Antibiotic Stewardship Program is a collaborative effort of community leadership, nursing associates, physicians and pharmacists focused on continuous improvement in the use of antibiotic agents in an effort to combat the emergence of resistant organisms. This community realizes the importance of this program as a necessary component of an overall patient/resident infection prevention program. Policy Detail: c) Document monthly infections and antibiotic usage utilizing the Infection Trend tracker. During a review of the facility's P&P titled, Infection Prevention and Surveillance dated 1/2020, the P&P indicated, Each resident shall be reviewed for infectious diseases upon admission and on an on-going basis. B. Nurse Leader Designee: 1. Shall apply scientific principles and methods to determine if the infection meets the criteria.		

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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.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure the call light was easily accessible for three of 46 sampled residents (Resident 12, Resident 102, and Resident 62). This failure resulted in Resident 12, Resident 102, and Resident 62 being unable to call staff and to have unmet care needs. Findings: During an interview on 12/1/25 at 9:29 a.m. with Resident 12, Resident 12 stated his call light was not within reach. Resident 12 stated this made him feel very frustrated. During an interview on 12/1/25 at 9:30 a.m. with Resident 12's Family Members (FM) 3 and FM 4 at bedside, FM 3 and FM 4 had watery and teary eyes. FM 4 stated, When we get here, his [Resident 12] head is away from the bed and he [Resident 12] can't reach the call light, and he [Resident 12] doesn't have his phone near him, it makes me sad. During a review of Resident 12's Care Plan (CP), dated 11/10/25, the CP indicated, Be sure [Resident 12] call light is within reach. During a concurrent observation and interview on 12/1/25 at 10:08 a.m. with Certified Nursing Assistant (CNA) 6, in Resident 102's room, Resident 102 was laying in his bed with the call light hanging on the side of the bed, not within reach. CNA 6 stated the call light should not be hanging and should be within reach. During a review of Resident 102's CP, dated 7/2/25, the CP indicated, Encourage the resident to use call bell for assistance. During an observation and interview on 12/1/25 at 12:37 p.m. with Resident 62, in Resident 62's room, a Licensed Vocational Nurse (LVN) 3 connected Resident 62 with feeding tube (delivers nutrition (food, water, medicine) through a flexible tube directly into the stomach or small intestine for people who can't eat enough by mouth). When LVN 3 was done with the care, she left the room without providing Resident 62's call light within reach. Resident 62 stated, When the nurses leave they forget to give me the call light. I am waiting for hours for them to come in to assist me because I can not tell them I need help. When asked where his call light was, Resident 62 stated, I don't know. The call light was on his left side not within Resident 62's reach. During an observation and interview on 12/1/25 at 12:46 p.m. with LVN 3, in Resident 62's room, the call light was not within reach. LVN 3 stated Resident 62 required assistance with call light. LVN 3 stated the call light was not within reach. During a review of Resident 62's Minimum Data Set (MDS-assessment tool), dated 11/14/25, the MDS indicated Resident 62 had a Brief Interview for Mental Status (BIMS) score of 15 (score of 13-15 means cognitive intact). During a review of the facility's policy and procedure (P&P) titled, Resident Call System and Door Alarm, dated 10/2022, the P&P indicated, Call system should be accessible to residents. During a review of the facility's policy and procedure (P&P) titled, Quality of Life - Accommodation of Needs, dated 10/2025, the P&P indicated, assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being. During a review of the facility's policy and procedure (P&P) titled, Supporting Activities of Daily Living (ADL), dated 9/2025, the P&P indicated, Residents should be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).		

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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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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 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. Based on observation, interview, and record review the facility failed to develop and implement a comprehensive care plan (CP) for one of 46 sampled residents (Resident 12). This failure had the potential to result in Resident 12 having an unrecognized change in condition and adverse health outcomes. Findings: During an observation on 12/1/25 at 9:29 a.m. with Resident 12, in Resident 12's room. Resident 12 was receiving intravenous (into the vein) Total Parenteral Nutrition (TPN - a method of delivering complete nutrition directly into the blood stream via an intravenous when the person's digestive system can not absorb nutrients from food). During a review of Resident 12's CP, dated 11/25/25, the CP indicated, [Resident 12] with TPN orders with oral gratification. During a concurrent interview and record review on 12/4/25 at 11:56 a.m. with Registered Nurse (RN) 2, Resident 12's clinical records was reviewed. Resident 12's clinical record indicated there was no record of monitoring Resident 12 receiving TPN. RN 2 stated they (staff) were not checking Resident 12's blood sugar and had no other monitoring. RN 2 stated Resident 12's CP was not comprehensive and not implemented to reflect the Policy and Procedure (P&P) on CP. During a review of the facility P&P, Comprehensive Care Plan, dated 11/2017, the P&P indicated, A comprehensive person centered care plan will be developed for each resident that includes measurable objects and time frames to meet the residents medical, nursing, mental and psychosocial needs that I have been identified through a comprehensive assessment. The comprehensive care plan will describe treatments and services to assist a resident to attain or maintain the highest level of physical mental and psychosocial well-being.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review, the facility failed to ensure one of 46 sampled resident (Resident 119) had dentures in place and assisted with meals. This failure had the potential for Resident 119 not being assisted with activities of daily living and not meeting her nutritional needs. Findings:During a concurrent observation and interview on 12/1/25 at 12:54 p.m. with Resident 119, in Resident 119's Room, Resident 119's lunch was provided. Resident 119's dentures were in a container on her bedside table. Resident 119 stated she could not open and clean her dentures. Resident 119 stated her food was not cut up for her to eat. Resident 119 stated she needed help and there was no staff present to assist.During a concurrent observation and interview on 12/1/25 at 12:56 p.m. with Registered Nurse (RN) 1, RN 1 stated Resident 119 needs help with her dentures to eat her lunch, Resident 119 said she can't do it, her lunch was just put on the tray without her dentures being in her mouth for her to eat. RN 1 was observed leaving the room without assisting Resident 119.During a review of Resident 119's Care Plan (CP) dated 11/25/25, the CP indicated, [Resident 119] requires staff assistance for feeding.During a review of the facility's policy and procedure (P&P) titled, Quality of Life - Accommodation of Needs, dated 10/2025, the P&P indicated, assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being.During a review of the facility's P&P titled, Supporting Activities of Daily Living (ADL), dated 9/2025, the P&P indicated, Residents who are unable to carry out activities of daily living independently should receive the services necessary to maintain good nutrition.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess and complete the Skilled Nursing Dialysis Center Communication Form (SNDCCF - a communication tool to be completed by the nursing home and sent with each resident hemodialysis [a treatment that filters waste and excess fluid from your blood when your kidneys are failing] treatment) for one of two sampled residents (Resident 131). This failure had the potential for a change in condition to not be identified and delay in provision of care for Resident 131 who was receiving hemodialysis treatments. Findings: During a review of Resident 131's Order Summary Report (OSR), dated [DATE], the OSR indicated, Dialysis Evaluation Form Post Treatment every Mon [Monday], Wed [Wednesday], Fri [Friday]. During a review of Resident 131's Care Plan Report (CPR), dated [DATE], the CPR indicated, [Resident 131] needs hemodialysis. Interventions/Tasks: Monitor for redness, swelling, or drainage, tunneled dialysis catheter [flexible tube tunneled under the skin (usually in the neck) into a large vein near the heart] left upper chest, monitor edema [swelling], shortness of breath, chest pain, or increased blood pressure [the force of blood pushing against artery walls] as they may indicate fluid overload. Report abnormalities to physician, vital signs as ordered, Send dialysis communication form [SNDCCF] with resident [131] to dialysis. During a concurrent interview and record review on [DATE] at 2:42 p.m. with Registered Nurse (RN) 2, Resident 131's SNDCCF dated [DATE] and [DATE] were reviewed. The SNDCCF indicated on [DATE], Dialysis Unit - Return Form After Each Treatment: [blank]. Charge Nurse to Complete This Section When Resident Returns Form Dialysis: [blank]. Resident 131's SNDCCF dated [DATE] indicated, Charge Nurse to Complete This Section When Resident Returns From Dialysis: [blank]. RN 2 stated the evening shift nurse did not complete the SNDCCF. During an interview on [DATE] at 2:58 p.m. with Licensed Vocational Nurse (LVN) 5 (evening shift nurse), LVN 5 stated she did not complete Resident 131's SNDCCF on [DATE] and [DATE] and should have. During a review of the facility's policy and procedure (P&P) titled, Dialysis Care dated 12/15, the P&P indicated, Record Keeping: Communication on resident status to the outpatient dialysis facility will include the information identified above using the Skilled Nursing Dialysis Center Communication Form.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure a meal was served at a palatable and appetizing appearance for one of 30 sampled residents (Resident 74). This failure resulted in Resident 74 not eating her meals and potential for not meeting her nutritional needs. Findings: During a concurrent observation and interview on 12/1/25 at 12:44 p.m. with Resident 74, in Resident 74's room, Resident 74's meal tray was on her overbed table. Resident 74's food was untouched. The plate contained mixed green and brown food. Resident 74 stated, Would you eat that? [pointing to the plate with food]. It looks like someone had a sick stomach and threw up. During a review of Resident 74's Meal Ticket, dated 12/1/25, the Meal Ticket indicated, Broccoli Chicken Casserole. During an interview on 12/2/25 at 11:31 a.m. with Certified Dietary Manager (CDM), CDM stated the food could have been presented better. CDM stated, It's a casserole, when it scooped, it mixes, the food should be in a small boat [bowl] to look better. CDM stated the facility had no policy and procedure on food appearance and palatability.		