

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555877	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2024
NAME OF PROVIDER OR SUPPLIER  Ridgecrest Regional Transitional Care and Rehabili		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 North China Lake Boulevard Ridgecrest, CA 93555	

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)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>50409</p> <p>Based on interview and record review, the facility failed to follow its policy and procedure (P&amp;P) on recording and investigating grievances or complaints for one of three sampled residents (Resident 1) when Resident 1's grievance reports were not resolved, and Resident 1 was not informed of the findings of the investigation, as well as any corrective actions recommended. This failure had the potential to result in Resident 1 to develop adverse health outcomes from potentially experiencing repeated concerns from unresolved grievances.</p> <p>Findings:</p> <p>During a review of Resident 1's Record of Admission (ROA), dated 4/20/23, the ROA indicated, Admitting/Subsequent Diagnoses. Type 2 diabetes mellitus (a disease that occurs when the body does not use insulin [a hormone or medication that lowers blood sugar] properly, resulting in high blood sugar).</p> <p>During an interview on 12/18/24 at 11:14 a.m. with Resident 1, Resident 1 stated she had filed multiple grievances. Resident 1 stated she had not been informed of the findings, and the facility's corrective actions for some of her grievances. Resident 1 stated there was an incident on 11/26/24 when she did not receive a dinner tray and she had to buy food because she was scared her blood sugar will drop too low. Resident 1 stated, I filed a grievance, but nobody had talked to me about it.</p> <p>During a concurrent interview and record review on 12/18/24 at 12:49 p.m. with Social Services Designee (SSD), Resident 1's Resident/Family Concern/Grievance Report (RGR), dated 11/1/24 and 11/26/24 were reviewed. The RGR dated 11/1/24 indicated, The kitchen door slams loud. Please adjust the door mechanism, it's disturbing. The RGR dated 11/26/24 indicated, My dinner tray never showed up! I had to buy my food \$25 KFC! It's now 7:30 pm no food from kitchen. New CNAs (Certified Nursing Assistant) did not deliver my tray. I got shaky w/ (with) insulin in me all that time! The RGRs indicated no documentation of the name of the person investigating the incident, the date the resident was informed of the findings, and the disposition of the grievance. SSD stated the RGRs were not resolved, and nobody had discussed the grievances with Resident 1. SSD stated grievances were supposed to be investigated and resolved within five working days. SSD stated, I've been a little bit all over the place with the grievances.</p> <p>(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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/18/24 at 1:34 p.m. with Administrator, Administrator stated the resolution for the grievances were supposed to be documented and discussed with the resident. Administrator stated, If it's (resolution) not documented, it didn't happen. Administrator stated the facility has 14 working days to notify the resident or the filing party of the grievance's findings and resolution.</p> <p>During an interview on 12/18/24 at 3:06 p.m. with Dietary Supervisor (DS), DS stated, I've never seen a grievance for the kitchen. I was not informed.</p> <p>During a review of the facility's P&amp;P titled, Grievances/Complaints, Recording and Investigating, dated April 2017, the P&amp;P indicated, All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievance(s). The grievance officer will record and maintain all grievances and complaints on the Resident Grievance Complaint Log. The following information will be recorded and maintained in the log. The name of the person(s) investigating the incident; f. The date the resident, or interested party, was informed of the findings; and g. The disposition of the grievance (i.e., resolved, dispute, etc.) . The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within 14 working days of the filing of the grievance or complaint.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>50409</p> <p>Based on interview and record review, the facility failed to follow its policy and procedure (P&amp;P) on administering medications for one of three sampled residents (Resident 1) when Resident 1's two insulin medications were not administered in a timely manner. This failure had the potential to result in Resident 1 to develop adverse health outcomes.</p> <p>Findings:</p> <p>During a review of Resident 1's Record of Admission (ROA), dated 4/20/23, the ROA indicated, Admitting/Subsequent Diagnoses. Type 2 diabetes mellitus (a disease that occurs when the body does not use insulin [a hormone or medication that lowers blood sugar] properly, resulting in high blood sugar).</p> <p>During an interview on 12/18/24 at 11:14 a.m. with Resident 1, Resident 1 stated she has been getting her insulin more than an hour too late or too early. Resident 1 stated, It was making me anxious and nervous. I had shortness of breath. I was shaky.</p> <p>During a concurrent interview and record review on 12/18/24 at 2:32 p.m. with Director of Nursing (DON), Resident 1's Medication Administration Record (MAR), dated December 2024 was reviewed. The MAR indicated, ADMINISTRATION ORDER TEXT. Insulin Human Regular (short-acting type of insulin [starts to work quickly and taken before meals to prevent blood sugar levels from rising too high]). The MAR indicated Resident 1 did not receive her Insulin Human Regular as scheduled on the following dates: a. On 12/16/24, the insulin was scheduled at 11 a.m. and was given at 2:01 p.m. b. On 12/15/24, the insulin was scheduled at 9 p.m. and was given on 12/16/24 at 3:27 a.m. c. On 12/12/24, the insulin was scheduled at 11 a.m. and was given at 2:14 p.m. d. On 12/11/24, the insulin was scheduled at 11 a.m. and was given at 2:54 p.m. e. On 12/8/24, the insulin was scheduled at 6 a.m. and was given at 9:01 a.m. f. On 12/6/24, the insulin was scheduled at 11 a.m. and was given at 1:50 p.m. g. On 12/5/24, the insulin was scheduled at 11 a.m. and was given at 1:13 p.m. DON stated there was no documentation Resident 1 received her insulin on time. DON stated, I expect it (insulin) is given in a timely manner. I consider these, late administration. DON stated, Expectation for any medication is you chart it as you are giving it.</p> <p>During a concurrent interview and record review on 12/18/24 at 2:43 p.m. with DON, Resident 1's MAR, dated December 2024 was reviewed. The MAR indicated, ADMINISTRATION ORDER TEXT. Insulin Glargine (long-acting type of insulin [provides a slow and steady release of insulin into the blood]). The MAR indicated Resident 1 did not receive her Insulin Glargine as scheduled on the following dates: a. On 12/17/24, the insulin was scheduled at 9 a.m. and was given at 3 p.m. b. On 12/13/24, the insulin was scheduled at 9 a.m. and was given at 12:09 p.m. DON stated there was no documentation Resident 1 received her insulin on time.</p> <p>During an interview on 12/18/24 at 2:55 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, We (licensed nurses) have to document on the MAR right after giving it (medications).</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/18/24 at 3:04 p.m. with LVN 2, LVN 2 stated medication administration is documented on the MAR right after the medication is given. LVN 2 stated, More than an hour (from scheduled time of medication order) is considered late.</p> <p>During a review of the facility's P&amp;P titled, Administering Medications, dated April 2019, the P&amp;P indicated, Medications are administered in a safe and timely manner, and as prescribed. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.</p>		