STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555877	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Regional Transitional Care and Rehabili	1081 North China Lake Boulevard Ridgecrest, CA 93555

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow infection control practices for 33 of 33 sampled residents when:1. A Water Management Program (WMP) was not developed and implemented to identify, assess, monitor, and prevent the potential growth of opportunistic waterborne pathogens (germs that grow well in water) in the facility's water system. This failure had the potential to result in serious illness or death of residents, visitors, and staff. 2. Linens and other laundry items were left wet and unattended in washing machines after environmental services staff work shift ended. This had the potential to result in growth of mold (type of fungus), mildew (type of fungus or mold) and bacteria (organisms that can cause infection) and illness of residents, staff, and visitors.Findings: 1. During an interview on 2/25/26 at 9:39 a.m. with Infection Preventionist (IP), IP stated the WMP was overseen by the maintenance department and the hospital. IP stated he did not participate in the WMP for the facility. IP stated he does not participate in the identification or prevention of potential water borne pathogens at the facility. During a concurrent interview and record review on 2/25/26 at 11 a.m. with Maintenance Supervisor (MS), a policy and procedure (P&P) titled, [Hospital Name] Domestic Water Management Plan, dated 1/7/20 was reviewed. The P&P indicated , This policy identifies all hospital water systems. MS stated the P&P was for the Hospital and did not include the long-term care facility. MS stated the facility did not have a P&P for WMP. MS stated he did not have training for WMP and was unable to verbalize areas within the facility that were at for risk for bacteria growth in the water system. MS was unable to verbalize measures used to mitigate and monitor the risk of growth. MS was unable to identify control limits and parameters of the measures used. MS stated there was no diagram or documentation of description of the facility water system with identified areas of concern for growth. During a review of the Center for Disease Control (CDC) document titled, Toolkit for Controlling Legionella [bacteria that can grow in man-made water systems like cooling towers and plumbing, especially in warm water] in Common Sources of Exposure (LCT - Legionella Control Toolkit), dated 12/26/24, the LCT indicated, [S] Sediment [Mineral build-up in a water system that uses up disinfectant and encourages growth of bacteria] and biofilm [layer produced by germs that stick to and grow on moist surfaces; provides an environment for growth of bacteria including Legionella], Temperature [T], water Age [A], and disinfectant Residuals [R] (STAR) are the key factors that affect Legionella growth in potable [water that is safe for ingestion] water systems. A comprehensive WMP allows water system operators to layer a series of complementary control measures to create environmental conditions that prevent bacterial intrusion, growth, and transmission. Develop or refine a WMP with the following guidelines in mind: . Monitor temperature, disinfectant residuals, and pH [potential of hydrogen - measures a substance's acidity or alkalinity] frequently. Store hot water at temperatures above 140 F [Fahrenheit] and ensure hot water in circulation does not fall below 120 F. Store and circulate cold water at temperatures below the favorable range for Legionella 77-113 F. Ensure a disinfectant residual [Chlorine (disinfectant added to tap water as a disinfectant to kill harmful bacteria) and Monochloramine (longer-lasting disinfectant)] is detectable throughout the potable water system. Flush low-flow piping runs and dead legs at least weekly and flush infrequently used fixtures (e.g., eye wash stations, emergency showers) regularly as-needed to maintain water quality (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	parameters within control limits. Clean and maintain water system components, such as thermostatic mixing valves, aerators, showerheads, hoses, filters, and storage tanks, regularly. 2. During an observation on 2/25/26 at 3:44 p.m. in the laundry area, two washing machines contained white linens and blue mop heads. No staff were present in the laundry area. During an interview on 2/25/26 at 3:58 p.m. with IP, IP stated the laundry staff leave at 3 p.m. each day and there was no staff in laundry at night. During a concurrent observation and interview on 2/25/26 at 4 p.m. with IP in the laundry area, IP opened a washing machine that contained white linens. IP stated the linens were damp and warm. IP opened the second washing machine that contained blue mop heads. IP stated the mop heads were also damp and warm. IP stated the laundry staff should have finished washing and drying the linen and mop heads before leaving for the day. During an interview on 2/25/26 at 4:06 p.m. with IP and Environmental Services Supervisor (EVSS), IP confirmed with EVSS that laundry staff were gone for the day. EVSS stated the linens and mop heads were not to be in the washing machines overnight. IP stated there were concerns for mold and bacterial growth. During a review of the facility's P&P titled, Safety - Laundry, dated 10/25/25, the P&P indicated, Turn off all equipment and leave the doors to washers and dryers slightly ajar when closing the Laundry at the end of the day. Do not leave laundry unattended.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a discharge notice was sent to Ombudsman (representatives who assist residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences) for one of two sampled residents (Resident 88). This failure had the potential to result in Resident 88 not having an advocate who could inform them of their admission, transfer, and discharge rights and options.Findings:During a concurrent interview and record review on 2/25/26 at 1:51 p.m. with Minimum Data Set Coordinator (MDSC), Resident 88's admission Record (AR), undated was reviewed. The AR indicated Resident 88 was discharged to home on [DATE]. MDSC stated Resident 88 was discharged home and the Ombudsman was not notified.During a review of the facility's policy and procedure (P&P) titled, Transfer or Discharge Notices, dated 2001, the P&P indicated, 4. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to accurately complete the annual Pre-admission Screening and Resident Review (PASRR-federal requirement to help ensure that individuals are not incorrectly placed in nursing homes or long-term care instead of a psychiatric setting) for one of one sampled resident (Resident 12). This failure had the potential for Resident 12 to be placed in an inappropriate setting and not receive required services. Findings:During a review of Resident 12's Preadmission Screening and Resident Review (PASRR -mandatory federal program which requires Residents to be screened for mental illness or intellectual disability/developmental disability) Level 1 Screening, dated 9/24/25, the PASRR indicated, Level I-positive for (SMI) [serious mental illness].During a concurrent interview and record review on 2/26/26 at 2:10 p.m. with Minimum Data Set Coordinator (MDSC), Resident 12's Notice of Attempted Evaluation (NAE-for SNF residents, a new Level I screening must be submitted to restart the process), dated 9/28/25 was reviewed. The NAE indicated, Unable to complete level II evaluation for serious mental illness (SMI).Facility staff [long term care staff] were unresponsive to two or more separate attempts of communication within 48 hours of the Level I Screening. MDSC stated the PASRR level II was not completed for Resident 12.During a review of the facility's policy and procedure (P&P) titled, admission Criteria, dated 2019, the P&P indicated, 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process: b. If the Level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process.Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the medical record was complete and accurate when physician's verbal order and change in condition physician notification was not documented in the Electronic Medical Record (EMR) for one of six sampled residents (Resident 82). This failure had the potential for Resident 82 to not have his medical needs met which could result in a negative health outcome. Findings:During a review of Resident 82's admission Record (AR), dated 2/25/26, the AR indicated Resident 82 was admitted to the facility on [DATE].During a concurrent interview and record review on 2/24/25 at 3:34 p.m. with Director of Nursing (DON), Resident 82's Physician Order (PO), dated 1/25/26 to 2/24/26 were reviewed. DON stated she was unable to provide documentation of a physician order or notice of a change in condition for Resident 82's transfer to the hospital emergency room on 1/25/26. DON stated it was the expectation of the facility nursing staff to document the physician notification and the physician's order in the Resident's EMR. During a concurrent interview and record review on 2/24/25 at 3:40 p.m. with Licensed Vocational Nurse (LVN) 8, Resident 82's EMR was reviewed. LVN 8 stated on 1/25/26 he was Resident 82's nurse. LVN 8 stated Resident 82 had decreased urine output on 1/25/26. LVN 8 stated Registered Nurse (RN) 9 attempted to flush Patient 82's suprapubic catheter (a thin, flexible tube inserted through a small abdominal incision directly into the bladder to drain urine) but was unsuccessful. LVN 8 stated he telephoned the physician to inform him of Resident 82's change in condition and the physician gave a verbal order (VO) for Resident 82 to be sent to the hospital emergency room. LVN 8 was unable to find the physician's VO in the EMR or documentation the physician was notified of Resident 82's change in condition. LVN 8 stated he got caught up in the transfer and forgot to document the physician notification and the VO. LVN 8 stated he should have documented the information in Patient 82's EMR.During a review of the facility's policy and procedures (P&P) titled, Verbal Order, dated 2001, the P&P indicated, The individual receiving the verbal order must write it on the physician's order sheet as verbal order or t.o. (telephone order).During a review of the facility's P&P titled, Change in a Resident's Condition or Status, dated 2001, the P&P indicated, Our facility promptly notifies the residents, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status.The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.During a review of the facility's P&P titled, Charting and Documentation, dated 2001, the P&P indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy interpretation and implementation 1. Documentation in the medical record may be electronic, manual or a combination. 2. The following information is to be documented in the resident medical record.Change in the resident's condition.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents' (Resident 66) was free from medication error rate of greater than five percent (%) when two medication errors occurred within 35 opportunities resulting in a 5.51% error rate. This failure had the potential for Resident 66 not receiving the full therapeutic effects of the medication and potential for adverse health outcomes. Findings:During an observation on 2/25/26 at 8:38 a.m. in Resident 66's room, Registered Nurse (RN) 1 administered Resident 66's morning (a.m.) medications. RN 1 stated to Resident 66 she (RN 1) did not have two of her medications to administer, lisinopril (medication to treat high blood pressure) and fluoxetine (medication to treat depression).During an interview on 2/25/26 at 8:39 a.m. with RN 1, RN 1 stated she did not administer Resident 66's lisinopril and fluoxetine because they were not available. RN 1 stated the pharmacy should have been notified regarding the unavailability of the medications and this was not done. During a review of Resident 66's Medication Administration Record (MAR), dated February 2026, the MAR indicated, 2/25/26 at 8 a.m. Lisinopril Tablet 10 mg (milligram) Give 1 tablet by mouth one time a day for hypertension, and Fluoxetine Capsule 20 MG Give 1 capsule by mouth one time a day for depression. No check mark was documented to indicate the lisinopril and fluoxetine were given to Resident 66.During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).