

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555902	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Height Street Skilled Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1611 Height Street Bakersfield, CA 93305	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>50409</p> <p>Based on interview and record review, the facility failed to report an allegation of resident to resident altercation to CDPH (California Department of Public Health [state agency]) within 24 hours between two sampled residents (Resident 1 and Resident 2). This failure resulted in CDPH being unaware of the allegation, and had the potential to result in continual physical and psychosocial harm for both Resident 1 and Resident 2.</p> <p>Findings:</p> <p>During a review of Resident 1's MD/NP Progress Notes (MPN), dated 11/26/24, the MPN indicated, Writer was alerted to possible resident to resident altercation. Resident nurse stated that resident (Resident 1) had come to her and made an excited utterance stating that another resident had 'run over' her foot and 'punched' her in the face twice. However, resident later denied that the other resident had made physical contact. Resident also indicated that they each started yelling at each other and commented that she had 4 brothers growing up so she 'knows how to swear like them.'</p> <p>During a review of Resident 2's MPN, dated 11/26/24, the MPN indicated, Resident does admit to a verbal 'loud' exchange where she stated that both residents were yelling at each other. While probable that resident (Resident 2) was involved in resident to resident altercation, Resident physical examination and interview indicates that it is unlikely that physical contact was made.</p> <p>During a review of Resident 1's SBAR (Situation, Background, Assessment, Recommendation), dated 11/26/24, the SBAR indicated, Resident (1) came to nursing station 1 and reported to charge nurse that another resident (Resident 2) run over her right foot/toes and punched her twice on her left side of the face at the back gazebo smoking area.</p> <p>During a review of Resident 1's IDT (Interdisciplinary Team), dated 11/27/24, the IDT indicated, According to witness (Resident 3), (Resident 2) and (Resident 1) engaged in loud verbal cursing at each other.</p> <p>During a review of Resident 1's Psychosocial Note (PN), dated 11/27/24, the PN indicated, Resident (1) continues alert and able to make needs known. Resident (1) verbalized having a verbal altercation with another female resident (Resident 2) due to the other resident accidentally bump her foot with the WC (wheelchair) and that incident happened on 11/26/24.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Brief Interview for Mental Status (BIMS) Evaluation, dated 7/8/24, the BIMS indicated Resident 1 had a score of 15 (score of 13-15 indicates intact cognitive response).</p> <p>During an interview on 12/11/24 at 2:55 p.m. with Resident 1, Resident 1 stated, We (residents) were just smoking right there (at the back gazebo smoking area). She was so close to my toes she ran over my toes. I said, ' Get off my foot.' Then she yelled at me, ' No the f*** I ain't. I'm not on your f***** feet you f***** b****!' She said something to the effect of, ' I'm gonna kick your f***** a**!' I was in shock I haven't been called that. Resident 1 stated she felt she was mistreated and harassed.</p> <p>During an interview on 12/11/24 at 3:34 p.m. with Resident 3, Resident 3 stated he witnessed the altercation between Resident 1 and Resident 2 at the back gazebo smoking area on 11/26/24. Resident 3 stated, I saw (Resident 2) basically tried to punch (Resident 1). I know (Resident 2) made contact with (Resident 1). (Resident 2's) first punch did not land but she continued to strike on (Resident 1), like open hand slaps, some landed on (Resident 1's) face and her feet was also rammed over. (Resident 1) was trying to make her move out of the way and at the same time (Resident 2) was assaulting her, cursing, and yelling at her.</p> <p>During a review of Resident 3's BIMS, dated 10/10/24, the BIMS indicated Resident 3 had a score of 15 (score of 13-15 indicates intact cognitive response).</p> <p>During an interview on 12/11/24 at 3:42 p.m. with Registered Nurse (RN) 1, RN 1 stated, It (Resident 1 and Resident 2's altercation on 11/26/24) is considered abuse. We have to notify the state with SOC 341 because they were yelling, or they used language that were not appropriate. We need to report (all allegations of abuse and abuse incidents) so that you guys (CDPH) can investigate what happened.</p> <p>During an interview on 12/11/24 at 4:05 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, It (Resident 1 and Resident 2's altercation on 11/26/24) was a verbal altercation. It is considered verbal abuse. LVN 1 stated, It should've been reported to CDPH.</p> <p>During an interview on 12/11/24 at 4:20 p.m. with Social Services Director (SSD), SSD stated, If someone is alleging an abuse. I thought we do report. I thought we do our investigation.</p> <p>During a concurrent interview and record review on 12/11/24 at 5:01 p.m. with Director of Nursing (DON), SOC 341, dated 11/26/24 was reviewed. SOC 341 (Report of Suspected Dependent Adult/Elder Abuse) indicated, Resident (1) has a verbal altercation with another resident (Resident 2). SOC 341 indicated it was not faxed to CDPH. DON stated, For me yes cursing is verbal abuse especially if they threaten each other. DON stated the facility should have reported Resident 1 and Resident 2's altercation to CDPH. DON stated the facility did not follow the facility's policy on abuse reporting.</p> <p>During an interview on 12/11/24 at 5:26 p.m. with Administrator, Administrator stated he was the facility's abuse coordinator. Administrator stated, If there was any suspicion of abuse then we do everything (investigate and report). Administrator stated Resident 1 and Resident 2's altercation on 11/26/24 was not reported. Administrator stated allegations of abuse were supposed to be reported to the Ombudsman, CDPH, and the police department.</p> <p>(continued on next page)</p>		

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