STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555902	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Height Street Skilled Care	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)
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** 37797 Based on observation, interview, and record review, the facility failed to implement the care plan (comprehensive documents outlining the care and services to be provided by the facility to residents) intervention of providing supervision during toilet transfers for one of three sampled residents (Resident 1), who had generalized muscle weakness, a history of falls, was at risk for falls, and had Alzheimer's Disease (memory loss), when Resident 1 got up unsupervised to use the toilet and fell in her room. This failure resulted in Resident 1 sustaining a fall with fracture (broken bone), requiring admission, and surgical intervention at the acute care hospital. Findings: During a review of Resident 1's Admission Record (AR), dated 1/23/25, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Schizoaffective Disorder (false perception of reality with mood symptoms), Cognitive Communication Deficits (inability to communicate), Spondylosis (degeneration of the spine), Osteoarthritis (degeneration of joints causing pain and stiffness), Generalized Muscle Weakness, Difficulty Walking, Need for Assistance with Personal Care, and History of Falling. During a review of Resident 1's Minimum Data Set (MDS) (a comprehensive assessment tool), dated 8/6/24, the MDS indicated Resident 1 had a Brief Interview for Mental Status (BIMS - a mental/intellectual test) score of 5 (scores of 0-7 indicate severe cognitive (how the person thinks, learn and understand] impairment). The MDS indicated Resident 1 needed assistance and supervision with personal hygiene, toileting, getting up and transferring from bed, chair and toilet, and used a wheelchair as a mobility (moving) device. During a review of Resident 1's Fall Prevention Care Plan (FPCP), initiated 5/4/23 and last revised 2/17/24, the FPCP indicated the following fall prevention interventions: resident's call light within reach and encourage the resident to use it for assistance (initiated 5/14/23); educate resident about safety reminders (initiated 5/4/23); encourage resident to participate in activities (initiated 5/4/23); anticipate and meet the resident's needs (initiated 8/16/23); ensure resident is wearing appropriate footwear (initiated 8/16/23); follow facility fall protocol (initiated 8/16/23); physical therapy as needed (initiated 8/16/23); safe environment (initiated 8/16/23); bed and wheelchair in lock position (initiated 11/16/23); keep bed in lowest position when care not being provided (initiated 11/16/23); and pressure pad alarm in bed and wheelchair to alert staff when resident attempting to get up unassisted (initiated 2/17/24). (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	During a review of Resident 1's Activities of Daily Living Care Plan (ADLCP), dated 3/16/24, the ADLCP indicated, TRANSFER: [Resident 1] requires supervision with 1 person staff between surfaces and as necessary. During a review of Resident 1's Fall Risk Evaluation (FRE), dated 8/6/24, the FRE indicated Resident 1 was at risk for falls. The FRE indicated Resident 1 had a history of falls, was confused, and had predisposing health conditions that increased the risk of falls. Three of the four sections of the FRE were blank: Section AS_2 Gait Balance (where the facility has to indicate if the resident has balance problems while standing or walking); Section AS_3 Medications (where the facility has to indicate if the resident is taking medications that increase the risk of falls such as medications to treat hypertension (high blood pressure), psychotropics or medications that affect the mood or cognition), and Section AS_4 Clinical Suggestions (where the facility has to indicate interventions to prevent falls for the resident). The FRE contained fields for staff to indicate fall preventions interventions to be implemented for Resident 1, such as Assist Resident with ambulation and transfers . and Utilize toileting program . The fields for these interventions were unselected and blank. During a review of Resident 1's Situation Background Assessments and Recommendations (SBAR) note, dated 1/21/25 at 9:20 a.m., the SBAR indicated: Situation: unwitnessed fall. Background: Alzheimer's disease, difficulty in walking; Assessment: [Licensed Nurse 1] was passing medications to the next room when the pressure alarm on the bed began beeping. [Licensed Nurse 1] went in the room, [Licensed Nurse 1] found the [Resident 1] lying on the floor. [Resident 1] complained of pain in her left hip . [Resident 1] verbally stated she was heading to the bathroom. [Resident 1's Physician] was contacted and receive order to transfer [Resident 1] to the hospital for further evaluation and treatment. Ambulance arrived and transported [Resident 1] to hospital. During a review of the hospital's History and Physical (H&P) dated 1/21/25, the H&P indicated: Chief Complaint: report of fall .complains of left hip pain. Assessment/Plan: acute [sudden, recent] left femoral neck [thigh bone] fracture s/p [status post/after] fall. During a review of the hospital's Operative and Procedure Reports (OPR), dated 1/23/25, the OPR indicated: Operative Diagnosis: Left Traumatic Intertrochanteric Femur [hip] Fracture. Procedure: Left Hip Intertrochanteric fracture fixation [hip surgery] with a cephanomedullary nail [surgical device to treat fracture]. During an interview with Licensed Nurse 1 (LN 1) on 1/23/25, at 11:41 a.m., LN 1 stated on 1/21/25 at around 9 a.m., she was in the hallway passing medications to residents when she heard Resident 1's bed alarm. LN 1 stated she went into Resident 1's room and found Resident 1 lying on the floor, next to her bed. LN 1 stated Resident 1 reported to her she fell while trying to go the bathroom and indicated left hip pain. LN 1 stated Resident 1 was taken to the hospital for evaluation and treatment. LN 1 stated the fall was unwitnessed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 2/28/25 at 1:20 p.m. with the Director of Nursing (DON) Resident 1's ADL (Activities of Daily Living) Flowsheets (where Certified Nursing Assistants document care), dated January 2025 was reviewed. The ADL Flowsheets indicated no documentation Resident 1 was provided toileting supervision or assistance on 1/21/25 (date of fall incident). The DON stated Resident 1 was not on a toileting program (scheduled toileting-fixed schedule). The DON stated at the time of the fall Resident 1 had a bed alarm to alert staff when she gets out of the bed. The DON stated staff relied on the bed alarm to know when Resident 1 was getting out of bed. The DON stated at the time of the fall Resident 1 received the same supervision as all other residents, meaning that Certified Nursing Assistants (CNAs) checked on Resident 1 every two hours. The DON stated CNAs did not document Resident 1's monitoring. During a concurrent observation and interview on 2/28/25, at 3:15 p.m., with Resident 2, who shared the same room with Resident 1, in her room, Resident 2's bed was next to Resident 1's bed and was directly in front of the bathroom and had an unobstructed view of the bathroom. Resident 2 stated she witnessed Resident 1's fall on 1/21/25. Resident 2 stated Resident 1 got out of bed and went to the bathroom unassisted by staff. After Resident 1 left the bathroom, and on her way back to her bed, Resident 1 lost her balance and fell to the floor. Resident 2 stated she pressed her call light to alert staff of Resident 1's fall. Resident 2 stated she heard no alarms or any noise when Resident 1 got out of bed. Resident 2 stated staff only came to the room to check on Resident 1 after she (Resident 2) pressed the call light. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 1 had a BIMS score of 14 (scores of 13-15 means intact cognition). During a review of facility policy and procedure (P&P) titled, Care Planning dated 3/28/17, the P&P indicated, Consistent with the facility's policy of providing appropriate care and services to residents admitted to the facility. Procedures: .6. Resident Care Plan must address the needs, strengths, and preferences of the resident as identified in the comprehensive assessment. 7. Services that are furnished for resident to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being are to be included in the plan of care. During a review of facility policy and procedure (P&P) titled Activities of Daily Living , dated 10/14/15, the P&P indicated: Each resident will be assisted to achieve and maintain the highest level of self-care. All residents will be given the appropriate treatment and services to maintain or improve their abilities. Residents who are unable to carry out activities of daily living will receive the necessary services to maintain good hygiene. Staff will ensure resident has the adequate support when providing care. This includes the residents' ability to the following: transfers. During a review of facility policy and procedure (P&P) titled Fall Prevention Policy , dated 10/14/15, the P&P indicated: It is this facility's policy to prevent falls to the extent possible and within the control of the facility. Plans of care shall include interventions on the following: provision of monitoring and supervision to resident to prevent fall incident. Residents identified to be at greater risk for fall or further falls should be monitored closely to prevent further occurrence of fall incident.