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	04/01/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37697 Based on interview and record review, the facility failed to ensure one of 11 sampled residents (Resident 1) received quality care when the facility failed to: 1. Implement their policy and procedure on a change of condition (an important change in a resident ' s baseline condition which includes physical, mental, emotional or functional changes that require a change in treatment to address) for one of 11 sampled residents (Resident 1). 2. Ensure the MDS assessment (Minimum Data Set - an assessment tool) was accurate for one of 11 sampled residents (Resident 1) when contractures (when your skin, muscles, tendons [tough, ropelike cords that connect muscles to bones, enabling movement], or ligaments [tough tissues that act like ropes or bands connecting bones to other bones providing stability and allowing for movement] get permanently stiff or shortened, making it hard to move the affected area) were not inputted into the assessment. 3. Ensure Restorative Nursing Assistant (RNA - a person that provides therapy to residents) orders reflected to one of 11 sampled residents (Resident 1) ability to complete/participate in. 4. Obtain necessary medical equipment for one of 11 sampled Residents (Resident 1). 5. Document accurately the time spent with one of 11 sampled residents (Resident 1) during therapy. These failures resulted in the worsening of Resident 1 ' s right hand contracture. Findings: During a review of Resident 1 ' s ADMISSION RECORD (AR), dated 4/14/25, the AR indicated, Resident 1 was admitted to the facility on [DATE]. The AR indicated Resident 1 had a diagnosis of Dementia (A brain disorder that affects thinking, movement, behavior, and mood, often causing visual hallucinations and changes in alertness), and neurocognitive disorder with Lewy bodies (a progressive brain disorder characterized by the presence of Lewy bodies[little clumps of a protein that abnormally form inside brain cells] in brain cells, leading to cognitive decline, movement issues, and behavioral changes). (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 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s MDS Assessment, under the section Brief Interview for Mental Status (BIMS - an assessment of cognition [how well a person thinks, remembers, and learns] with scores ranging from 0 - 15, the higher the score the more intact the resident ' s cognition is. A score of 99 is the resident was unable to complete the interview and therefore unable to determine the resident ' s cognition), dated 1/1/25, the BIMS score indicated, Resident 1 ' s BIMS score was 99. The MDS assessment dated [DATE], under section GG (assesses functional abilities and goals), Resident 1 was documented as completely dependent on staff for all activities of daily living (ADL refers to the basic, everyday tasks needed focusing on personal care and hygiene such as eating, dressing, bathing, and using the bathroom). 1.During a review of Resident 1 ' s OT (Occupational Therapy - a health profession that helps people of all ages with activities of daily living and improves their ability to engage in meaningful activities) Evaluation and Plan for Treatment (OTEPT), dated 12/22/24, the OTEPT indicated, Resident 1 had contractures of her muscles to multiple sites (no documentation to indicate what muscles) with an onset date of 12/22/24. During a concurrent interview and record review on 4/14/25 at 12:20 p.m. with Director of Nursing (DON) 2, Resident 1 ' s Electronic Medical Record (EMR) was reviewed. DON 2 stated Resident 1 was admitted to the facility on [DATE] with no contractures. DON 2 stated therapy documented Resident 1 had contractures on 12/22/24. DON 2 stated a change of condition should have been implemented but was not. DON 2 stated the medical doctor, and family should have been notified about the change in Resident 1 ' s condition but were not. During a review of the facility ' s policy and procedure (P&P) titled, Change of Condition Notification, dated 6/1/17, the P&P indicated, To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. An acute change of condition (ACOC) is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains. Clinically important means a deviation that, without intervention, may result in complications or death. The Facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal representative when the resident endures a significant change in their condition caused by, but not limited to . An injury/accident . A significant change in the resident ' s physical, cognitive, behavioral or functional status . A significant change in treatment . The Licensed Nurse will notify the resident ' s Attending Physician when there is an . A significant change in the resident's physical, mental or psychosocial status, e.g., deterioration in health, mental or psychosocial status, life-threatening conditions or clinical complications . The Licensed Nurse will assess the resident ' s change of condition and document the observations and symptoms. The Attending Physician will be notified timely with a resident ' s change in condition. Notification to the Attending Physician will include a summary of the condition change and an assessment of the resident ' s vital signs and system review focusing on the condition and/or signs and symptoms for which the notification is required. 2.During a review of Resident 1 ' s Condition on Admission (CAD), dated 11/10/22, the CAD indicated Resident 1 was admitted with no contractures. During a review of Resident 1 ' s OTEPT, dated 12/22/24, the OTEPT indicated Resident 1 had contractures of her muscles to multiple sites with an onset date of 12/22/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 4/9/25 at 1:30 p.m. with Minimum Data Set Nurse (MDSN), Resident 1 ' s MDS assessments for 10/1/24, 1/2/25 and 4/2/25, were reviewed. MDSN stated, Resident 1 was assessed to be dependent on all aspects of care, Resident 1 was unable to communicate, was not alert and oriented, and was at increased risk for contractures to her upper extremities (arms), but there was no documentation Resident 1 had contractures on 10/1/24, 1/2/25 and 4/2/25. During a review of Resident 1 ' s Care Plan (CP), dated 1/9/24, the CP indicated Resident 1 was at potential risk for complications related to a diagnosis of osteoarthritis (a progressive disorder of the joints [a point where two or more bones connect], caused by a gradual loss of cartilage [A tough, flexible tissue that lines joints]). The CP indicated Resident 1 would be free of complications from her osteoarthritis which included developing contractures. The CP dated 12/22/24 indicated Resident 1 was referred to therapy for contractures to her right and left hands. The CP indicated Resident 1 would have a resting hand splint (a device that positions a resident in a way that provides a stretch to improve range of motion and prevents further tightening of muscles) to her right wrist and a palmar guard splint (a device used to prevent your fingers from digging in to the palm of your hand, to prevent skin damage and prevent further deformity) to her left hand. During a concurrent observation and interview on 4/9/25 at 3:12 p.m. with MDSN, in Resident 1 ' s room, MDSN assessed Resident 1. MDSN stated Resident 1 could not move her upper extremities very well and she had a noted contracture to her right hand (did not mention her left hand). MDSN stated the MDS assessment completed on 1/2/25 and 4/2/25 was incorrect and should have mentioned Resident 1 ' s contracture to right hand (section GG of the MDS). MDSN stated the MDS (1/2/25 and 4/2/25) for Resident 1 indicated no impairment regarding her upper extremities. MDSN stated a new CP should have been created for Resident 1 that identified her contractures and the plan of care for staff (not just therapy) to follow. During a review of the facility ' s policy and procedure (P&P) titled, RAI (Resident Assessment Instrument - an assessment and care planning process used to ensure residents receive the highest quality of care and quality of life) Process, dated 10/1/19, the P&P indicated, To ensure that the Resident Assessment Instrument (RAI) is used, in accordance with specified format and timeframes, in conducting comprehensive assessments as part of an ongoing process through which the facility identifies each resident ' s preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessment once problems have been identified. The Facility will utilize the Resident Assessment Instrument (RAI) process as the basis for the accurate assessment of each resident ' s functional capacity and health status . The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The quarterly MDS does not require the completion of Care Area Assessments (CAAs). However, the resident ' s care plan must be reviewed and revised by the interdisciplinary team after each assessment. 3.During a review of Resident 1 ' s Physician Orders (PO), dated 2/27/25, the PO indicated, a PO for RNA (Restorative Nursing Assistant - a nursing aide with additional training in restorative care, focusing on helping residents regain and maintain their physical abilities) to provide active range of motion (AROM - the movement of a joint that is achieved through the voluntary and unassisted contraction of surrounding muscles) and passive range of motion (PROM - the movement of a joint through its range of motion by an external force, such as a therapist or a machine, without any muscle effort from the individual) three times a week. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/9/25 at 2 p.m. with RNA 1, RNA 1 stated, she has been providing RNA treatment to Resident 1 since 2/2025. RNA 1 stated she provided PROM to Resident 1 but not AROM because Resident 1 was dependent in all areas of care and the resident could not actively participate in AROM. RNA 1 stated Resident 1 had been on the RNA program since 2/2025 and had not been able to participate in AROM. RNA 1 stated she meets with leadership (not specific who) every Monday to discuss the RNA program but had not brought up the need to clarify Resident 1 ' s AROM physician ' s order (during the one-day remainder of February, the 31 days in March, and nine days in April). During a concurrent observation and interview on 4/9/25 at 3:12 p.m. with MDSN in Resident 1 ' s room, MDSN assessed Resident 1. MDSN stated Resident 1 could not move her upper extremities on her own for AROM and she could not move her upper extremities past her shoulders when being provided with PROM. During a review of the facility ' s policy and procedure (P&P) titled, Specialized Rehabilitative Services, dated 6/1/17, the P&P indicated, The Facility shall meet the assessed needs of any resident admitted to assist them in obtaining or maintaining their highest practicable level of functional well-being. Skilled therapies will be provided to any resident based on physician order, validation of assessed needs . 4. During a review of Resident 1 ' s OTEPT dated 12/22/24, the OTEPT indicated, Resident 1, noted with contractures and would benefit from splinting . in order to reduce risk for skin breakdown and increased contractures. During a review of Resident 1 ' s CP dated 12/22/24, the CP indicated Resident 1 was referred to therapy for contractures to her right and left hands. The CP indicated Resident 1 would have a resting hand splint to her right wrist. During a review of Resident 1 ' s Occupational Therapy OT Therapy Progress Report (OTPR), dated 2/5/25, the OTPR indicated: 1a. On 12/22/24 - Resident 1 need for splint was indicated for her right-hand contracture and it would be ordered for her use. 2b. On 1/24/25 - Resident 1 ' s splint was still pending. 3c. On 1/31/25 - Resident 1 ' s had not obtained her splint. 4d. On 2/5/25 - (Resident 1) noted with increased contracture to (right) hand would benefit from hand roll splint (a type of splint that uses a rolled or inflatable device to help position the hand and fingers in a way that promotes healing or reduces contractures) . During an interview on 4/9/25 at 2:51 p.m. with Central Supply Manager (CSM), CSM stated, he had never received a request for Resident 1 ' s right hand splint. The CSM stated all requests for equipment are made verbally and there is no documentation conducted by either him or central supply staff for a splint for Resident 1. CSM stated a splint for Resident 1 was never obtained. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 4/11/24 at 1:58 p.m. with State Director (SD - person in charge of the rehabilitation directors in California), Resident 1 ' s Electronic Medical Chart (EMR), dated 12/2024 to 2/2025 was reviewed. SD verified Resident 1 had less function to her right hand after therapy services were started. SD verified there were therapy notes which indicated Resident 1 was evaluated and needed a splint for her right-hand contracture on 12/22/24. SD reviewed the therapy notes and indicated Resident 1 never received the splint. SD stated the expectation she had for the facility therapy group was for them to document in detail and to inform the facility if a resident needed medical equipment. 5.During a review of Resident 1 ' s Physician Order (PO), dated 12/22/24, the PO indicated, Resident 1 was to have OT twice a week for six weeks to reduce the risk of increased contractures and skin breakdown. During a review of Resident 1 ' s OTEPT, dated 12/22/24, the OTEPT indicated Resident 1 was to be seen by OT two times a week for six weeks from 12/22/24 to 2/1/25 with an intensity of daily. During an interview on 4/2/25 at 10:32 a.m. with Physical Therapy Assistant (PTA), PTA stated she had reported to SD and Director of Rehabilitation (DOR) that Physical Therapist (PT) 1 falsified the amount of time he (PT 1) spent with residents (specific residents not given) for therapy. PTA stated, He (PT 1) was not spending the amount of time he billed for as a telehealth physical therapist. PTA stated due to low staff, residents were not evaluated during their 24-to-48-hour window, therapy treatments were not done, and residents that should have discontinued therapy services were not taken off. PTA stated for example if a resident was to be seen five times a week, the facility therapy group was not able to meet that number of times but would charge/document as if they did. PTA stated OT 1 would fraudulently document time spent with residents. PTA stated with residents (not specific) that needed evaluations, facility therapy group would not have therapist physically be in the facility nor via telehealth but input documentation at 10 or 11 p.m. when residents would be asleep/in bed. During an interview on 4/2/25 at 2:44 p.m. with Certified Occupational Therapy Assistant (COTA) 2, COTA 2 stated, the facility therapy group did not have enough staff. During an interview on 4/2/25 at 3:20 p.m. with Rehabilitation Technician (RT) 2, RT 2 stated, she observed PT 1 see 12 to 15 residents in 30 minutes and document more time was spent. RT 2 stated PT 1 would wait for OT 2 to complete resident evaluations and then copy her notes. RT 2 stated she had reported PT 1 ' s actions to DOR and nothing was done. During an interview on 4/4/25 at 11:05 p.m. with OT 2, OT 2 stated she was out of the country in January 2025 and when she returned there was a lot of documentation not completed due to not having enough therapy staff. OT 2 stated she observed Facility Therapist (FT) have over 30 therapy notes due and document on them all without ever seeing the resident. OT 2 stated FT had documented working with Resident 1 despite not seeing her and when she followed up, she (OT 2) had noticed the contracture had worsened. OT 2 stated FT not seeing Resident 1 despite documentation had resulted in her harm because the identified treatment needed was not given. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s OTPR, dated 2/5/25, the OTPR indicated, on 2/5/25 - Pt (Resident 1) noted with increased contracture to (right) hand would benefit from hand roll splint (a type of splint that uses a rolled or inflatable device to help position the hand and fingers in a way that promotes healing or reduces contractures) . During a review of Resident 1 ' s OT Discharge Summary (OTDC), dated 2/20/25, the OTDC indicated, Resident 1 had been on therapy service since 12/22/25 and required a hand roll to her right hand due to increased contracture. During a concurrent interview and record review on 4/11/24 at 1:58 p.m. with SD, Resident 1 ' s Electronic Medical Chart (EMR), dated 12/2024 to 2/2025 was reviewed. SD stated on 2/5/25 a therapy note indicated Resident 1 should have been discharged from therapy services and placed on RNA. SD could not explain why Resident 1 continued to be in therapy services for 15 more days (2/20/25) after the note indicated she (Resident 1) needed to be discharged nor how Resident 1 had less function of her right hand after therapy services were started. During an interview on 4/22/25 at 2:34 p.m. with DOR, DOR stated, he had never been informed of any concerns with falsified documentation, falsified minutes spent with a resident or encouraged falsification of any type. DOR stated his expectation for therapy staff is they, Should be documenting honestly and I (DOR) did not encourage any type of fraud. DOR stated if a resident is set up for 60 minutes of therapy and could only do 45 minutes, then the total minutes should be 45 reflecting what the resident was able to accomplish. During an interview on 4/22/25 at 3:43 p.m. with SD, SD stated, it is difficult to staff the facility with therapy. SD stated her expectation for therapy staff is for them to document as accurately as possible. SD stated to her recollection she could not recall any issues brought forth about falsified documentation or falsified minutes spent with residents. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of RT 1 ' s email statement (ES), dated 4/7/25, the ES indicated, RT 1 had been directed by DOR to bill for 11 hours of work despite having completed all job duties by 12:30 p.m. (workday started at 7:30 a.m.). RT 1 ' s ES indicated on 3/17/25 RT 1 had questioned SD how to accurately document her timecard as there were many inconsistencies. RT 1 ' s ES indicated RT 1 was on a call with SD and Rehabilitation Clinical Director (RCD) and had asked why she had been asked by DOR to log in time for a complete shift when in reality she had only worked three to four hours. RT 1 ' s ES indicated RCD told RT 1 she was being inconsiderate considering the time the facility therapy group spent training her and that her question was offensive. RT 1 ' s ES indicated RT 1 had asked SD and RCD about only spending two to three minutes with each resident, but documenting time spent was 25 minutes, 30 minutes, and even up to 60 minutes. RT 1 ' s ES indicated SD told RT 1 not to worry about the accuracy of the times as it was not her concern for the position she was in. RT 1 ' s ES indicated on 3/17/25 RT 1 had assisted SD, Doctorate Physical Therapist (DPT), and OT 1 with resident (not specified) therapy. RT 1 ' s ES indicated SD, DPT, and OT 1 had only spent three to four minutes with each resident (not specific). RT 1 ' s ES indicated on 3/18/25 RT 1 had contacted SD and DOR about not wanting to participate in fraud and the response was that her concern was, noted. RT 1 ' s ES indicated on 3/26/25 RT 1 had spoken to COTA 1 about her timecard and COTA 1 responded, Just do whatever. It doesn't matter. We make up things with our time card (sic). RT 1 ' s ES indicated RT 1 had spoken with Therapy [NAME] President (TVP) (date not given) about her timecard and she had been told to not worry about it since she was not the one doing the billing. RT 1 ' s ES indicated TVP told RT 1 that in worst case scenario the state comes to audit the therapy hours, it would be very difficult to prove. RT 1 ' s ES indicated TVP stated, If anything, maybe what is happening is that the therapists are evaluating (residents) and providing telehealth sessions to (residents) who do not qualify to receive therapy. RT 1 ' s ES indicated RT 1 had reported to TVP about OT 1 not participating in the resident telehealth sessions but documented as if had. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility therapy group email (FTE), dated 10/2/24, the FTE indicated, PTA had emailed DOR, SD, and RCD, . I (PTA) advised previously of what (nonspecific residents) where (sic) reporting, that they had not been seen. (OT 2) has also expressed that when she does progress notes, following (Unknown facility therapy group member) (evaluation), that the goals do not pertain to that (resident not identified). He (unknown facility therapy group member) was often referencing a female when (resident not identified) was in fact male or vice versa. This email is not being composed with the intent to accuse however; this has been an ongoing thing when he (unknown facility therapy group member) evaluates a (nonspecific resident). The history and/or goals including PLOF (prior level of function) are not reflective of the (nonspecific resident). The FTE dated 2/4/25 indicated OT 2 emailed DOR and RCD regarding past-due documentation and missed therapy treatments due to staffing issues. The FTE dated 2/5/25, indicated OT 2 sent an email to [NAME] President of Compliance (VPC). The 2/5/25 FTE indicated, I (OT 2) have previously reached out to (DOR, RCD, SD, and VPC) regarding several concerns, including lack of OT supervision for my (nonspecific residents), missed frequencies (how often therapy is given), and potential compliance issues. Unfortunately, I (OT 2) have not received clear responses, and this situation is negatively impacting my (nonspecific residents) and placing my license at risk. Due to staffing constraints, my (COTA) (not specifically identified) has reported missed visits [due to staffing constraints], and I (OT 2) have been asked to complete non-billable notes. Some (nonspecific residents) have not seen an OT for their 10th visits or are not receiving adequate OT supervision. Additionally, I was advised to co-treat (treating with another discipline) with the Physical Therapy (PT), but not all of my (nonspecific residents) are suitable for this model. As a result, I am unsure how to proceed with the delayed documentation for (nonspecific residents) I have not seen for cases where the available notes lack sufficient detail .Also, I have noticed that another OT (not identified) [who does not work in the building] was asked to complete recertification and progress notes without seeing the (nonspecific resident) and documenting levels without assessments and there is no billing which has been completed, which is unethical. I (OT 2) am not comfortable with what is going on. I (OT 2) am afraid of retaliation by bringing this to your attention, but this issue is not ethical, and this is a disservice to our (residents). During a review of the facility ' s P&P titled, Documentation, dated 3/11/24, the P&P indicated, Medical record documentation primarily is a means of communication. Documentation facilitates coordination and continuity of care, guides effective treatment to optimize outcomes, justifies billing of services provided, and serves as a legal document. Documentation integrity involves the accuracy of the facts in the medical record. This policy establishes standard guidelines for documentation completion in support of accuracy and meets requirements set forth by federal regulations. If a state or local law is more stringent, the most stringent regulations must be followed. Documentation must be timely, accurate, objective, thorough, and complete, and must present the appropriate facts .

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F 0825 Level of Harm - Actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37697 Based on interview and record review, the facility failed to provide and accurately document physical therapy (PT - branch of healthcare for the treatment of disease, injury, or deformity by physical methods such as massage, heat treatment, and exercise), occupational therapy (OT -branch of healthcare that helps people adapt to challenges in their daily lives, like getting dressed, eating, or working, by improving their ability to perform those activities) services and speech therapy (branch of healthcare that helps people with difficulties talking, understanding language, or swallowing) services, when the facility therapy staff inaccurately documented the time spent providing therapy to 11 of 11 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11). This failure resulted in Resident 1's right hand contracture (when one or more fingers get stuck in a bent position and can't be straightened) to worsen and had the potential to negatively impact the physical conditions for Resident 2, Resident 3, Resident 4 , Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, and Resident 11. Findings: During a review of Resident 1's ADMISSION RECORD (AR), dated [DATE], the AR indicated, Resident 1 was admitted to the facility on [DATE]. The AR indicated Resident 1 had a diagnosis of Dementia (A brain disorder that affects thinking, movement, behavior, and mood, often causing visual hallucinations and changes in alertness), and neurocognitive disorder with Lewy bodies (a progressive brain disorder characterized by the presence of Lewy bodies[little clumps of a protein that abnormally form inside brain cells] in brain cells, leading to cognitive decline, movement issues, and behavioral changes). During a review of Resident 1's Minimum Data Set (MDS - an assessment tool) under the section BIMS (Brief Interview for mental status) - an assessment of cognition [how well a person thinks, remembers, and learns]) Evaluation, the BIMS indicated, Resident 1 had a score of 99 (due to resident condition not able to assess cognition [how well a person thinks, remembers, and learns] function). The MDS under the section GG (an assessment of the level a care a resident required), dated [DATE], the GG indicated, Resident 1 was completely dependent on staff for all activities of daily living (ADL -the basic things we do every day to take care of ourselves, like eating, dressing, bathing, and using the bathroom). During a review of Resident 1's Care Plan Report (CPR), dated [DATE], the CPR indicated, Resident 1 had a potential for contractures (when your skin, muscles, tendons [tough, ropelike cords that connect muscles to bones, enabling movement], or ligaments [tough tissues that act like ropes or bands connecting bones to other bones providing stability and allowing for movement] get permanently stiff or shortened, making it hard to move the affected area). During a review of Resident 1's Physician Order (PO), dated [DATE], the PO indicated Resident 1 was to have OT twice a week for six weeks to reduce the risk of increased contractures and skin breakdown. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Height Street Skilled Care	1611 Height Street Bakersfield, CA 93305

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F 0825 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's OT Evaluation & Plan of Treatment (OTEPT), dated [DATE], the OTEPT indicated, Resident 1 was to be seen by OT two times a week for six weeks from [DATE] to [DATE] with an intensity of daily. The OTEPT indicated Resident 1, noted with contractures and would benefit from splinting (the application of a device, typically made of rigid material like plaster or metal, to support and immobilize an injured body part) and RNA (Restorative Nursing Assistant - a program to assist residents in regaining or maintaining their functional abilities) edu[cation] in order to reduce risk for skin breakdown and increased contractures. During a review of Resident 1's OT Service Log Matrix (SLM - document used to indicate total amount of minutes was spent on a resident for therapy on specific dates), dated [DATE] [DATE], and February 2025, the SML indicated the following documentation for Resident 1: 1. On [DATE] - 60 total OT minutes provided 2. On [DATE] - 30 total OT minutes provided 3. No further OT minutes provided were documented for the month of December 4. On [DATE] - 15 total OT minutes provided 5. On [DATE] - 30 total OT minutes provided 6. No further OT minutes provided were documented for Resident 1 until [DATE] 7. On [DATE] - 30 total OT minutes provided 8. On [DATE] - 23 total OT minutes provided 9. On [DATE] - 38 total OT minutes provided 10. No further OT minutes provided were documented for Resident 1 until [DATE] 11. On [DATE] - 25 total OT minutes provided 12. No further OT minutes provided were documented for Resident 1 until [DATE] 13. On [DATE] - 38 total OT minutes provided 14. On [DATE] - 38 total OT minutes provided 15. On [DATE] - 38 total OT minutes provided 16. On [DATE] - 38 total OT minutes provided 17. On [DATE] - 25 total OT minutes provided 18. On [DATE] - 24 total OT minutes provided (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Occupational Therapy OT Therapy Progress Report (OTPR), dated [DATE], the OTPR indicated: 1. On [DATE] - Resident 1 need for splint was indicated for her right hand contracture and it would be ordered for her use. 2. On [DATE] - Resident 1's splint was still pending. 3. On [DATE] - Resident 1's had not obtained her splint. 4. On [DATE] - Pt (Resident 1) noted with increased contracture to (right) hand would benefit from hand roll splint (a type of splint that uses a rolled or inflatable device to help position the hand and fingers in a way that promotes healing or reduces contractures) . During a concurrent interview and record review on [DATE] at 1:58 p.m. with State Director (SD), Resident 1's Electronic Medical Chart (EMR), dated ,d+[DATE] to [DATE], was reviewed. SD stated on [DATE] a note indicated Resident 1 should have been discharged from therapy services and placed on RNA. SD could not explain why Resident 1 continued to be in therapy services for 15 more days ([DATE]) after the note indicated she (Resident 1) needed to be discharged nor how Resident 1 had less function of her right hand after therapy services were started. SD verified there were therapy notes which indicated Resident 1 was evaluated to need a splint for her right hand contracture on [DATE] and notes which indicated Resident 1 never received the splint she was evaluated to need. SD stated the expectation she had for the facility therapy group staff was for them to document in detail to the best of their ability. During a review of Resident 2's admission MDS under the section BIMS Evaluation, dated [DATE], the BIMS indicated, Resident 2 had a score of 15 (cognition is intact). During an interview on [DATE] at 11:20 a.m. with Resident 2, Resident 2 stated he was admitted to the facility on [DATE]. Resident 2 stated when he is seen by therapy (PT and OT), they spent a total of five to 10 minutes providing therapy services (PT and OT) then the therapy would stop. During a review of Resident 2's PO, dated [DATE], the PO indicated, Resident 2 was to have PT five times a week for four weeks. During a review of Resident 2's PT Evaluation and Plan of Treatment (PTEPT), dated [DATE], the PTEPT indicated Resident 2 was to be seen by PT five times a week daily. During a review of Resident 2 ' s PT Service Log Matrix (SLM), dated [DATE], the SML indicated the following documentation for Resident 2: 1. On [DATE] - 60 total PT minutes provided 2. On [DATE] - 30 total PT minutes provided 3. On [DATE] - 32 total PT minutes provided 4. On [DATE] - 30 total PT minutes provided (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Few	5. On [DATE] - 30 total PT minutes provided 6. No further PT minutes provided were documented for Resident 2 until [DATE] (six days without PT) 6. On [DATE] - 30 total PT minutes provided 7. ON [DATE] - 30 total PT minutes provided During a review of Resident 2's PO, dated [DATE], the PO indicated, Resident 2 was to have OT three times a week for six weeks. During a review of Resident 2's OT Evaluation and Plan for Treatment (OTEPT), dated [DATE], the OTEPT indicated Resident 2 was to receive occupational therapy (OT - therapy focused on daily activities and task) three times a week daily. During a review of Resident 2's (OT) SLM, dated ,d+[DATE], the SLM indicated the following documentation for Resident 2: 1. On [DATE] - 60 total OT minutes provided 2. On [DATE] - 30 total OT minutes provided 3. On [DATE] - 30 total OT minutes provided 4. On [DATE] - 35 total OT minutes provided 5. On [DATE] - 15 total OT minutes provided 6. On [DATE] - 30 total OT minutes provided 7. On [DATE] - 30 total OT minutes provided During an interview on [DATE] at 11:36 a.m. with Family Member (FM) 1, FM 1 stated Resident 3 was provided therapy services by the facility therapy group. FM 1 stated when she observed Resident 3 therapy sessions (could not state which date but stated she was at facility everyday) it lasted about 10 minutes total (was not able to identify exact dates/times and which discipline). During a review of Resident 3 ' s PO, dated [DATE], the PO indicated, Resident 3 was to have OT three times a week for six weeks. During a review of Resident 3 ' s OTEPT, dated [DATE], the OTEPT indicated, Resident 3 was to be seen by OT three times a week for six weeks from [DATE] to [DATE] daily. During a review of Resident 3 ' s OT SLM, dated ,d+[DATE] and ,d+[DATE], the SLM indicated the following documentation for Resident 3: 1. On [DATE] - 60 total OT minutes provided (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Few	2. On [DATE] - 30 total OT minutes provided 3. On [DATE] - 30 total OT minutes provided 4. On [DATE] - 35 total OT minutes provided 5. On [DATE] - 40 total OT minutes provided 6. On [DATE] - 30 total OT minutes provided 7. On [DATE] - 30 total OT minutes provided There were no further OT minutes provided on [DATE] until [DATE]. During a review of Resident 3's PO, dated [DATE], the PO indicated, Resident 3 was to have PT five times a week for six weeks. During a review of Resident 3's PTEPT, dated [DATE], the PTEPT indicated, Resident 3 was to be seen by PT five times a week for six weeks from [DATE] to [DATE] daily. During a review of Resident 3's PT SLM, dated ,d+[DATE] and ,d+[DATE], the SML indicated the following documentation for Resident 3: 1. On [DATE] - 60 total PT minutes provided 2. On [DATE] - 30 total PT minutes provided 3. On [DATE] - 25 total PT minutes provided 4. On [DATE] - 30 total PT minutes provided 5. No further PT minutes provided were documented for Resident 3 until [DATE] 6. On [DATE] - 30 total PT minutes provided 7. No further PT minutes provided were documented for Resident 3 until [DATE] 8. On [DATE] - 15 total PT minutes provided 9. No further PT minutes provided were documented for Resident 3 until [DATE] 10. On [DATE] - 30 total PT minutes provided 11. On [DATE] - 30 total PT minutes provided 12. No further PT minutes provided were documented for Resident 3 until [DATE] 13. On [DATE] - 30 total PT minutes provided (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Few	14. No further PT minutes provided to Resident 3 documented until [DATE] During a review of Resident 3's PO, dated [DATE], the PO indicated, Resident 3 was to have ST evaluation and treatment (specific dates, times and completion date not indicated). During a review of Resident 3's ST SLP (speech language pathologist - title given to professionals who are trained to evaluate and treat communication and swallowing disorders) Evaluation and Plan of Treatment (STEPT), dated [DATE], the STEPT indicated, Resident 3 was to be seen by ST three times a week for 31 days from [DATE] to [DATE] daily. During a review of Resident 3's ST SLM, dated ,d+[DATE] and ,d+[DATE], the SML indicated the following documentation for Resident 3: 1. On [DATE] - 55 total ST minutes provided 2. On [DATE] - 36 total ST minutes provided 3. On [DATE] - 30 total ST minutes provided 4. No further ST minutes provided were documented for Resident 3 until [DATE] 5. On [DATE] - 36 total ST minutes provided 6. On [DATE] - 34 total ST minutes provided 7. On [DATE] - 30 total ST minutes provided 8. On [DATE] - 37 total ST minutes provided 9. On [DATE] - 42 total ST minutes provided 10. On [DATE] - 33 total ST minutes provided 11. On [DATE] - 30 total ST minutes provided 12. On [DATE] - 30 total ST minutes provided 13. No further ST minutes provided to Resident 3 documented until [DATE]. During a review of Resident 4's admission MDS under the section BIMS Evaluation, dated [DATE], the BIMS indicated, Resident 4 had a score of 14 (cognition intact). During an interview on [DATE] at 12:22 p.m. with Resident 4, Resident 4 stated he thought he was supposed to get therapy five times a week and had been getting therapy once or twice a week. Resident 4 stated therapy sessions total lasted approximately five to 10 minutes if working with arms and approximately half an hour if working on legs. (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 4's PO, dated [DATE], the PO indicated, Resident 4 was to have PT five times a week for four weeks. During a review of Resident 4's PTEPT, dated [DATE], the PTEPT indicated, Resident 4 was to be seen by PT five times a week daily. During a review of Resident 4's PT SLM, dated ,d+[DATE], ,d+[DATE], and ,d+[DATE], the SML indicated the following documentation for Resident 4: 1. On [DATE] - 30 total PT minutes provided 2. On [DATE] - 35 total PT minutes provided 3. On [DATE] - 40 total PT minutes provided 4. On [DATE] - 26 total PT minutes provided 5. On [DATE] - 30 total PT minutes provided 6. On [DATE] - 30 total PT minutes provided 7. No further PT minutes provided were documented for Resident 4 until [DATE] 8. On [DATE] - 30 total PT minutes provided 9. On [DATE] - 22 total PT minutes provided 10. On [DATE] - 35 total PT minutes provided 11. On [DATE] - 35 total PT minutes provided 12. On [DATE] - 20 total PT minutes provided 13. On [DATE] - 27 total PT minutes provided 14. On [DATE] - 35 total PT minutes provided 15. On [DATE] - 35 total PT minutes provided 16. On [DATE] - 39 total PT minutes provided 17. On [DATE] - 32 total PT minutes provided 18. On [DATE] - 30 total PT minutes provided 19. On [DATE] - 35 total PT minutes provided 20. On [DATE] - 30 total PT minutes provided (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Few	21. On [DATE] - 31 total PT minutes provided 22. On [DATE] - 32 total PT minutes provided 23. No further PT minutes provided were documented for Resident 4 until [DATE] 24. On [DATE] - 26 total PT minutes provided 25. On [DATE] - 35 total PT minutes provided 26. On [DATE] - 30 total PT minutes provided 27. On [DATE] - 30 total PT minutes provided 28. No further PT minutes provided were documented for Resident 4 until [DATE] 29. On [DATE] - 30 total PT minutes provided 30. No further PT minutes provided were documented for Resident 4 until [DATE] 31. On [DATE] - 30 total PT minutes provided 32. On [DATE] - 30 total PT minutes provided During a review of Resident 4's PO, dated [DATE], the PO indicated, Resident 4 was to have OT five times a week for 27 days. During a review of Resident 4's OTEPT, dated [DATE], the OTEPT indicated, Resident 4 was to be seen by OT five times a week daily. During a review of Resident 4's OT SLM, dated ,d+[DATE], ,d+[DATE], and ,d+[DATE], the SML indicated the following documentation for Resident 4: 1. On [DATE] - 60 total OT minutes were provided 2. On [DATE] - 30 total OT minutes were provided 3. On [DATE] - 30 total OT minutes provided 4. On [DATE] - 35 total OT minutes provided 5. No further OT minutes provided were documented for Resident 4 until [DATE] 6. On [DATE] - 30 total OT minutes provided 7. On [DATE] - 30 total OT minutes provided 8. On [DATE] - 30 total OT minutes provided (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Few	9. On [DATE] - 23 total OT minutes provided 10. On [DATE] - 38 total OT minutes provided 11. On [DATE] - 38 total OT minutes provided 12. On [DATE] - 15 total OT minutes provided 13. On [DATE] - 38 total OT minutes provided 14. On [DATE] - 38 total OT minutes provided 15. On [DATE] - 30 total OT minutes provided 16. On [DATE] - 38 total OT minutes provided 17. On [DATE] - 30 total OT minutes provided 18. On [DATE] - 30 total OT minutes provided 19. On [DATE] - 30 total OT minutes provided 20. On [DATE] - 35 total OT minutes provided 21. On [DATE] - 30 total OT minutes provided 22. On [DATE] - 30 total OT minutes provided 23. On [DATE] - 38 total OT minutes provided 24. On [DATE] - 35 total OT minutes provided 25. On [DATE] - 30 total OT minutes provided 26. On [DATE] - 30 total OT minutes provided 27. On [DATE] - 30 total OT minutes provided 28. On [DATE] - 45 total OT minutes provided 29. On [DATE] - 38 total OT minutes provided 30. On [DATE] - 38 total OT minutes provided 31. On [DATE] - 30 total OT minutes provided 32. On [DATE] - 30 total OT minutes provided (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Few	33. On [DATE] - 30 total OT minutes provided 34. On [DATE] - 30 total OT minutes provided 35. On [DATE] - 30 total OT minutes provided 36. On [DATE] - 30 total OT minutes provided During a review of Resident 5's admission MDS under the section BIMS Evaluation, dated [DATE], the BIMS indicated, Resident 5 had a score of 15. During a review of Resident 5's PO, dated [DATE], the PO indicated, Resident 5 was to have PT five times a week for four weeks. The PO indicated Resident 5 was to have OT five times a week for six weeks. During an interview on [DATE] at 12:34 p.m. with Resident 5, Resident 5 stated, he received therapy yesterday ([DATE]) for his upper and lower body. Resident 5 stated therapy lasted 30 minutes total for upper and lower body. During a review of Resident 5's PT and OT SLM, dated ,d+[DATE], the SML indicated the following: 1. On [DATE] - 30 total PT minutes were provided to Resident 5 documented, and 45 total OT minutes were provided to Resident 5 documented for a total time of 75 minutes of total therapy. During a review of Resident 6's quarterly MDS under the section BIMS Evaluation, dated [DATE], the BIMS indicated, Resident 6 had a score of 13 (cognition intact). During a review of Resident 6's PO, dated ,d+[DATE], the PO indicated, Resident 6 was to have OT three times a week for six weeks. During an interview on [DATE] at 12:49 p.m. with Resident 6, Resident 6 stated, she was admitted in October of 2024. According to what they (specific person not mentioned) tell me, I am still on it (therapy services). Resident 6 stated the last time she received therapy was yesterday ([DATE]) and it lasted 15 minutes. Resident 6 stated since [DATE] the therapy sessions are about 10 to 15 minutes total. During a review of Resident 6's OT SLM, dated ,d+[DATE], the SML indicated the following: 1. On [DATE] - 55 total OT minutes were provided to Resident 6 was documented. During an interview on [DATE] at 1:03 p.m. with facility therapy group Regional Clinical Director (RCD), RCD stated, the facility therapy group had trouble finding therapists to provide therapy service. RCD stated, We are meeting Medicare expectations (did not indicate what this meant nor how this was accomplished) to cover this building (facility). During an interview on [DATE] at 1:22 p.m. with Certified Occupational Therapist Assistant (COTA) 1, COTA 1 stated, regarding therapy documentation, the documentation should accurately reflect the actual number of minutes the therapist (PT, ST, OT) provided. (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 4:35 p.m. with Rehabilitation Technician (RT) 1, RT 1 stated facility therapy group was charging insurance for care provided to residents that is not accurate. RT 1 stated for example a therapist will work with a resident (no specific resident mentioned) for five minutes but document one hour of therapy provided, which was not true. RT 1 stated the therapy group relies heavily on telehealth therapy (using technology like video calls or online portals to get medical care without having to physically present with the patient/resident) but the therapist were observed doing other tasks (not relevant to resident treatment) rather than focusing on the treatment provided to the resident (no specific resident mentioned). RT 1 stated if the facility therapy group had six residents, they would charge for six hours of direct resident treatment but only actually do a total of 45 minutes for all six residents. RT 1 stated, Director of Rehabilitation (DOR) and Occupational Therapist (OT) 1 asked him to falsify time spent with residents (no specific resident mentioned). During an interview on [DATE] at 3:06 p.m. with Administrator, Administrator stated he could not recall who, could not recall when, but Administrator observed a therapist providing a therapy telehealth session with a resident (could not recall who) and the therapist was noted driving his/her car and was not focused on the resident. Administrator stated he had spoken to the facility therapy group (could not recall who) about this incident. During an interview on [DATE] at 10:32 a.m. with Physical Therapy Assistant (PTA), PTA stated she had reported Physical Therapist (PT) 1 to the State Director (SD - person in charge of the rehabilitation directors in California) and to DOR for falsifying time spent providing therapy services with residents (specific residents not given). PTA stated, He (PT 1) was not spending the amount of time he billed for as a telehealth physical therapist. PTA stated for example, if the physician ordered therapy services to be rendered five times a week and the facility therapy group could not meet the physician order, then the facility therapy group would document to show they were treated five times a week although they were not performing the treatment. PTA stated OT 1 would fraudulently document time spent with residents. PTA stated with residents (not specific) that required evaluations, facility therapy group would not have the therapist physically in the facility nor via telehealth but would document at 10 or 11 p.m. that services were provided but the residents were asleep in bed. During an interview on [DATE] at 2:44 p.m. with COTA 2, COTA 2 stated, the facility therapy group would conduct a lot of telehealth services because they did not have enough therapy staff. During an interview on [DATE] at 3:20 p.m. with RT 2, RT 2 stated the facility therapy group would have residents (not specific) that would not meet criteria to stay on therapy services, but the facility therapy group would keep the residents on and continue charging for services. RT 2 stated an example of residents not meeting criteria would be a resident (not specific) who would refuse to participate in therapy for a month, but the facility therapy group would keep them on for 100 days and charge for 100 days of therapy services. RT 2 stated PT 1 would see 12 to 15 residents in 30 minutes and document more time was spent. RT 2 stated PT 1 would wait for OT 2 to complete resident evaluations and then copy her notes. RT 2 stated she reported PT 1's actions to DOR and nothing was done. (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 11:05 p.m. with OT 2, OT 2 stated she would have residents in the facility (not specific) who would plateau (a state of little or no change) and no longer require therapy but DOR, SD, and RCD would not allow the residents to discontinue the therapy services. OT 2 stated she called her licensing board about this situation and the licensing board (name of person not given) told her the residents could not remain on therapy services. OT 2 stated for example, Resident 7 and Resident 8, would refuse to participate in therapy services/not progress yet PT 1 would document the residents were receiving therapy services despite the refusals; therefore, therapy services would continue. OT 2 stated she spoke to RCD about this, and RCD did nothing. OT 2 stated she was out of the country in [DATE] and when she returned there was a lot of documentation (of therapy services) not completed due to not enough staff. OT 2 stated residents (not specific) who should have received therapy services five times a week, did not receive their therapy as ordered. OT 2 stated Facility Therapist (FT) documented he conducted an evaluation on Resident 8, but FT did not conduct an evaluation on Resident 8. OT 2 stated this was reported to DOR who stated FT was just being overzealous (someone who is excessively eager) with his documentation. OT 2 stated FT would have over 30 therapy notes due and document on them all without ever physically seeing the resident. OT 2 stated FT documented working with Resident 1 for a contracture to right hand and when OT 2 followed up, she noticed the contracture to Resident 1 ' s hand had worsened. OT 2 stated FT was not seeing Resident 1 despite documentation, and this resulted in Resident 1 ' s harm. OT 2 stated Resident 9 would also refuse all therapy services, yet PT 1 documented an evaluation was done despite Resident 9 refusing to participate. OT 2 stated, COTA 2 documented Resident 10 participated in therapy, but it did not happen. OT 2 stated Resident 10, reported to her, he had never met COTA 2 or participated in therapy with COTA 2. During a review of Resident 7's CPR, dated [DATE], the CPR indicated, Resident 7 was, noncompliant (behavior that does not conform to or follow the rules, regulations, or advice of others) with therapy treatments. During a review of Resident 7's PO, dated [DATE], the PO indicated, Resident 7 was to have PT five times a week for four weeks. The PO on [DATE] indicated Resident 7 was to have PT five times a week for four weeks. During a review of Resident 7's PT SLM, dated ,d+[DATE], the SML indicated the following: 1. Resident 7 refused PT therapy on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. 2. Resident 7, when provided care by PT 1 was documented as participating in therapy on [DATE] for 23 minutes, [DATE] for 25 minutes, [DATE] for 30 minutes, [DATE] for 25 minutes, [DATE] for 34 minutes, [DATE] for 17 minutes, [DATE] for 25 minutes, and [DATE] for 25 minutes. During a review of Resident 9 ' s CPR, dated [DATE], the CPR indicated, Resident 9 had a mood problem related to history of refusing care and yelling/cursing at care staff. The CPR dated [DATE] indicated, Resident 9 was resistive to care, continues to refuse care when staff (not identified) switched to provide care. The CPR dated [DATE] indicated, Resident 9 refused to participate in the restorative nursing assistant (RNA) program and requested to have it discontinued. The CPR dated [DATE] indicated, Resident 9 was noncompliant with blood draws, bathing, meals, medications, activities of daily living, and vital signs. (continued on next page)

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	04/01/2025

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.

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F 0825 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 9's PO, dated [DATE], the PO indicated, Resident 9 was to have PT five times a week for four weeks. The PO dated [DATE] indicated Resident 9 was to have OT five times a week for four weeks. During a review of Resident 9's PT and OT SLM, dated ,d+[DATE] the SML indicated the following documentation for Resident 9: 1. On [DATE] - 75 total PT minutes provided 2. On [DATE] - Resident 9 refused PT 3. On [DATE] - Resident 9 refused PT 4. On [DATE] - 24 total PT minutes provided 5. On [DATE] - 26 total PT minutes provided 6. On [DATE] - Resident 9 was unavailable to do PT 7. On [DATE] - 30 total PT minutes provided 8. On [DATE] - Resident 9 refused PT 9. On [DATE] - 45 total PT minutes provided 9. On [DATE] - Resident 9 refused PT 10. On [DATE] - Resident 9 did not have PT due to a physician hold 11. On [DATE] - Resident 9 refused PT 12. On [DATE] - Resident 9 refused OT 13. On [DATE] - 60 total OT minutes provided 14. On [DATE] - 38 total OT minutes provided 15. On [DATE] - Resident 9 refused OT 16. On [DATE] - 15 total OT minutes provided 17. On [DATE] - 15 total OT minutes provided During a review of Resident 10's PO, dated [DATE], the PO indicated, Resident 10 was to have OT five times a week for four weeks. During a review of Resident 10's OT SLM, dated ,d+[DATE], the SML indicated, Resident 10 was provided care by COTA 2 on [DATE] for 53 minutes. (continued on next page)

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	04/01/2025

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F 0825 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 10's admission MDS under the section BIMS, dated [DATE], the BIMS indicated, Resident 10 had a score of 15. During an interview on [DATE] at 11:10 a.m. with Resident 10, Resident 10 stated, he had never received therapy from COTA 2. During an interview on [DATE] at 12:12 p.m. with COTA 2, COTA 2, stated he did not recall Resident 10. During an interview on [DATE] at 12:38 p.m. with Doctorate Physical Therapy (DPT), DPT stated, she had worked for the facility therapy group on [DATE] and noticed documentation had not been done in weeks. DPT stated on [DATE] she was assigned residents (not specific), and therapy certification documentation had not been done so she did not see them. DPT stated her concern with fraudulent documentation was more due to the frequencies (number of times a resident is to be seen). DPT stated for example if she made an evaluation and recommendation for a resident to be seen five times a week I (DPT) don ' t understand how they (facility therapy group) are doing that (seeing resident five times a week) with no staff. DPT stated, So my concern is how are we meeting the needs of the residents with not enough staff. During an interview on [DATE] at 2:34 p.m. with DOR, DOR stated, he had never been informed of any concerns with falsified documentation, falsified minutes spent with a resident or encouraged falsification of any type. DOR stated as a rule if a resident had refused to participate in therapy three consecutive times, they would be taken off service. DOR stated his expectation for therapy staff is they, Should be documenting honestly and I (DOR) did not encourage any type of fraud. DOR stated if a resident is set up for 60 minutes of therapy and could only do 45 minutes, then the total minutes should be 45 reflecting what the resident was able to accomplish. During an interview on [DATE] at 3:43 p.m. with SD, SD stated, it is difficult to staff the facility with therapy. SD stated the use of telehealth helps to meet the therapy staffing needs. SD stated the facility therapy group does not have any set criteria to determine when a resident should be taken of therapy services. SD stated her expectation for therapy staff is for them to document as accurately as possible. SD stated to her recollection she could not recall any issues brought forth about falsified documentation or falsified minutes spent with residents. During a review of the facility therapy group email (FTE), dated [DATE], the FTE indicated, PTA had informed DOR, SD, and RCD, (Resident 11) is a long-term resident and has been for at least 2 years. (Unknown facility therapy group member) did this (evaluation). I (PTA) advised previously of what (Residents) where (sic) reporting, that they had not been seen. (OT 2) has also expressed that when she does progress notes, following (Unknown facility therapy group member) (evaluation), that the goals do not pertain to that (resident). He (unknown facility therapy group member) was often referencing a female when (resident) was in fact male or vice versa. This email is not being composed with the intent to accuse however; this has been ongoing thing when he (unknown facility therapy group member) evaluates a (resident). The history and/or goals including PLOF (prior level of function) are not reflective of the (resident). The FTE dated [DATE], indicated OT 2 emailed