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	06/12/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure: 1. Three of three resident rooms (room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]) were clean and sanitary. This failure had the potential to spread infectious diseases to residents, staff, and visitors. 2. Environment had comfortable noise levels for two of two sampled residents (Resident 134 and Resident 31). This failure resulted in residents not getting rest and sleep. 3. One of 44 sampled resident (Resident 81) personal property was protected from theft and loss. This failure resulted in Resident 81's personal property not to be accounted for. Findings: 1. During an observation on [DATE] at 9:08 a.m. in room [ROOM NUMBER], the floor under the beds had thick debris and dusts like white particles. The room was occupied by two residents. Resident 24 was lying in bed with thick debris under his bed on the floor. The sliding door frame had thick dark colored debris. During an interview on [DATE] at 9:09 a.m. with Housekeeping/Laundry Supervisor (HLS), HLS stated, Under the bed is dusty. HLS looked at the sliding door frame and stated, Not good. During an interview on [DATE] at 9:13 a.m., with Housekeeper (HSK), HSK stated, There's a build up of dusts, if it cleaned yesterday, it should not be there [dusts]. During a concurrent observation and interview on [DATE] at 9:18 a.m. in room [ROOM NUMBER], with Resident 87, there were debris, carton of drink, chips, and a plastic bag were on the floor. Resident 87 stated, The dirt has been there for days. The chips, carton of drink and a plastic bag. There are dusts under my bed for several days. During a review of Resident 87's Minimum Data Set (MDS-comprehensive assessment tool), dated [DATE], the MDS indicated Resident 87 had a BIMS (Brief Interview for Mental Status) score of 15 (score of 13-15 means cognitively intact, score of 8-12 means moderately impaired, and 0-7 means severely impaired). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 9:34 a.m. in room [ROOM NUMBER], with Resident 134, there were white particles and debris on the floor. Resident 134 stated, The room is always dirty. During a review of facility policy and procedure (P&P) titled, Housekeeping-General dated [DATE], the P&P indicated, The housekeeping Staff's general duties are to: Sweep and mop, or vacuum, all floors. 2. During an interview on [DATE] at 9:34 a.m. with Resident 134, Resident 134 stated, The other room had a TV too loud, I can't get sleep at night. During a review of Resident 134's MDS, dated [DATE], the MDS indicated Resident 134 had a BIMS of 15 (. During a review of resident 134's Grievance/Complaint Report (GCR), dated [DATE], the GCR indicated, This is now the 3rd day of resident across the hall, who is deaf, who keeps the volume of his TV at the highest. It is disturbing. I got a headache for 2 days straight and had to take Advil [medication for pain]. I did not get any sleep the first night, was sick in the morning and had to take Zofran [medication for nausea] when I have to take medication because of a resident's TV is unacceptable. The volume was allowed even at night, overnight, all hours. Why are his rights higher than mine? During a concurrent observation and interview on [DATE] at 9:46 a.m. in Resident 31's room, with Resident 31, Resident 31's room mate (Resident 135) TV was on with moderate volume. Resident 31 stated he was not getting sleep due to room mate's TV was too loud at night for several nights. During a review of Resident 31's MDS, dated [DATE], the MDS indicated, Resident 31 had a BIMS of 15. During an interview on [DATE] at 10:33 a.m. with Social Services Director (SSD), SSD stated Resident 135 has hearing impairment and Resident 134's grievance was forwarded and will look into it. SSD stated the issue has not been resolved. During an interview on [DATE] at 4 p.m. with Administrator, Administrator stated he was aware of the complaint of Resident 134 about the TV of Resident 135 which gets too loud at night. During a review of facility policy and procedure (P&P) titled, Resident Rooms and Environment dated 1/2017, the P&P indicated, Facility staff aim to create personalize, homelike atmosphere, paying close attention to the following: Comfortable noise levels. 3. During an interview on [DATE] at 12:53 p.m. with Family Member (FM) 1, FM 1 stated the facility failed to protect resident property after Resident 81's death. FM 1 stated when she went to the facility to pick up Resident 81's personal property, they were unable to account for clothing and $620 in wallet. During a review of Resident 81's Health Status Note (HSN), dated [DATE], the HSN indicated Resident 81 expired at 7:45 p.m. and Resident 81's FM 1 picked up Resident 81's property at 8:30 p.m. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 81's Inventory List, dated [DATE], the Inventory List indicated Resident 81 had one belt, one shirt, one hat, a jacket, one pair of pants, one pair of socks, one undershirt, one watch, one wallet, $620, and upper denture. The Inventory list was signed by Resident 81 and facility staff upon admission. During a concurrent interview and record review on [DATE] at 2:31 p.m. with Director of Nursing (DON), DON stated on admission resident personal property is inventoried on the inventory list by staff and resident or FM sign the form in agreement, on discharge the resident or FM goes through the resident property and inventory list to ensure all property was accounted for then each signs the inventory sheet indicating all property list on admission was received. Resident 81's discharged inventory list was reviewed. DON stated Resident 81's inventory list was not completed or signed by staff and FM 1. During a review of the facility's P&P titled, Theft Prevention, dated [DATE], the P&P indicated, The Facility is committed to preventing the misappropriation of resident property. The Facility will exercise reasonable care for the protection of the resident's property from theft or loss. II. Measures to Secure Personal Property A. At the time of admission and discharge, Facility staff complete . Resident Inventory. i. Upon admission and upon request thereafter the facility provides the resident and/or his/her representative with a copy of the Resident Inventory. G. Upon the discharge or death of the resident, the facility provides the resident or his/her representative with a copy of the Resident inventory and the resident's property and obtains a signed receipt from the recipient.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Elder Abuse Prohibition and Prevention, when: 1. A thorough investigation of the resident-to-resident physical and verbal altercation for two of 44 sampled residents (Resident 16 and Resident 17) was completed. This failure had the potential for Resident 16 and Resident 17 not to be protected from further abuse. 2. A 5-day investigation report of the resident-to-resident physical and verbal altercation for two of 44 sampled residents (Resident 16 and Resident 17) was not submitted to the California Department of Public Health (CDPH) and the long-term care (LTC) ombudsman (advocate for the rights and well-being of residents in long-term care facilities). This failure had the potential for an incomplete investigation for Resident 16 and Resident 17. Findings: 1. During a concurrent interview and record review, on 6/10/25 at 2:32 p.m. with the Administrator, the Administrator stated the investigation was on the SOC 341 (Report of Suspected Dependent Adult/Elder Abuse). The Administrator stated he did not complete the investigation; he stated Licensed Vocational Nurse (LVN) 1 was responsible for the investigation. During an interview on 6/10/25 at 2:44 p.m. with LVN 1, LVN 1 stated she interviewed the staff members who witnessed the resident-to-resident physical and verbal altercation between Resident 16 and Resident 17. LVN 1 stated she did not interview other residents, she did not review Resident 16 and Resident 17 medical records for past history of aggression or behaviors, nor did she speak to other staff members who provided care for Resident 16 and Resident 17 prior to the altercation. LVN 1 stated she was not trained to investigate abuse she was just told to interview witnesses and residents involved. LVN 1 stated the SOC 341 contained the statement of what the staff witnessed and Resident 16 and Resident 17 reports of what happened. During a review of the facility's P&P titled, Elder Abuse Prohibition and Prevention, dated 11/10/22, the P&P indicated, Resident Abuse Investigation Guidelines .3. Whenever [Facility]receives an allegation of resident abuse from any source, the Abuse Committee will cause an immediate investigation to be made. 4. Investigation of all violations/alleged violations will be documented on the: . b) Written Report; .5. Investigation will include the: a) Type of incident. b) Possible existence of repeat incidents for individual residents. c) Determination of any trend or pattern. d) Discussion of possible causative factors. e) Recommendation for preventative measures .4. In the event of a resident -to-resident altercation . a) Determine the sequence of events before, during, and after the occurrence. 2. During an interview on 5/29/25 at 1:25 p.m. with the Administrator, the Administrator stated he did not send a 5-day investigation report to CDPH or the LTC ombudsman. The Administrator stated he never sends a five day investigation report. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Elder Abuse Prohibition and Prevention, dated 11/10/22, the P&P indicated, In response to allegations of abuse, . (2) Have evidence that all alleged violations are thoroughly investigated. (4) Report the results of all investigations to administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the appropriate corrective action must be taken.

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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. Based on observation, interview, and record review, the facility failed to: 1. Ensure medication was administered according to physician's order for one of five sampled residents (Resident 337). This failure had the potential to result in Resident 337 having adverse health outcomes. 2. Complete vital signs (temperature, heart rate, breathing rate, blood pressure, oxygen saturation [amount of oxygen in the blood], pain, and mental status) after seizure (sudden, uncontrolled electrical disturbance in the brain that can cause temporary changes in movement, awareness, or behavior) episodes for one of five sampled residents (Resident 85). This failure had the potential for Resident 85 to experience a delay in care due to an incomplete assessment. 3. Follow physician orders to have foot cradle (a device used to prevent blankets from touching the legs/feet) for one of eight sampled Residents (Resident 11). This failure had the potential for Resident 11 having worsening wound. Findings: 1. During a concurrent interview and record review on 6/11/25 at 8:30 a.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 was passing medications for Resident 337. LVN 6 stated there was no available Albuterol (breathing treatment) for Resident 337 in the medicine cart. LVN 6 stated she will give it later. During a review of Resident 337's Medication Administration Record (MAR), dated June 2025, the MAR indicated, Ipratropium-Albuterol Inhalation Aerosol Solution 20-100 MCG/ACT [microgram per actuation/release] 1 puff inhale orally four times a day related to Chronic Obstructive Pulmonary Disease [long term lung disease that makes breathing difficult] to be given at 9 a.m., 1 p.m., 5 p.m., and 9 p.m. The MAR indicated the albuterol was not given on 6/11/25 at 9 a.m. During a concurrent observation and interview on 6/11/25 at 11:22 a.m. (two hours and 52 minutes later), LVN 6 was giving medications to other residents. LVN 6 stated Resident 337's Albuterol for 9 a.m. dose was still not given to Resident 337 due to unable to locate the medication. LVN 6 stated she did not call the physician. LVN stated the 9 a.m. dose was missed. During a concurrent observation and interview on 6/11/25 at 11:30 a.m. with Resident 337, Resident 337 was lying in bed with oxygen via nasal tubing on her nostrils. Resident 337 stated she has not received her breathing treatment yet for the 9 a.m. dose. During a review of Resident 337's Minimum Data Set (MDS-comprehensive assessment tool), dated 6/4/25, the MDS indicated Resident 337 had a BIMS (Brief Interview of Mental Status) score of 15 (score of 13-15 means cognitively intact). During a review of facility's policy and procedure (P&P) titled, Medication - Errors, dated 6/1/17, the P&P indicated, A medication error may be administration or omission of medication. Errors related to the administration of medications or treatments will be reported to the Director of Nursing Services, by the Attending Physician, and the Administrator. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an observation and interview on 6/11/25 at 11:47 a.m. with Resident 11, Resident 11 was lying in bed with his legs flat. Resident 11 stated he has never had a foot cradle or device to use for his legs and feet. During an interview and observation on 6/12/25 at 11:35 a.m. with LVN 14, in Resident 11's room, Resident 11 did not have a foot cradle in the bed. LVN 14 stated she is familiar with Resident 11 and has never seen him with a foot cradle. During a concurrent interview and record review on 6/12/25 11:55 a.m. with LVN 14, Resident 11's Physician's Order (PO), dated 2/15/25 was reviewed. Resident 11's PO indicated, Foot cradle in bed, every shift. LVN 14 stated Resident 11 does not have a foot cradle. During a review of P&P titled, Physician Orders, dated 5/1/19, the P&P indicated, This will ensure that all physician orders are complete and accurate. The Medical Records Department will verify that physician orders are complete, accurate and clarified as necessary. X. Supplies/medications required to carry out the physician order will be ordered. 2. During an interview on 5/30/25 at 10:19 a.m. with Family Member (FM) 2, FM 2 stated she visited Resident 85 on 5/24/25 around 12:30 p.m. at the facility. FM 2 stated Resident 85 looked very tired, very distressed, and he had a fever. FM 2 stated the nurse just bypassed (brushed off) her when she reported Resident 85 had a fever. FM 2 stated Resident 85 had multiple seizure episodes with the first episode starting at 12:47 p.m., 1:06 p.m., 1:35 p.m., and 2:21 p.m. FM 2 stated Resident 85 was sent to the hospital on 5/24/25 at 2:30 pm. FM 2 stated at the emergency room, Resident 85 had a high heart rate and high temperature. During a concurrent interview and record review on 5/30/25 at 12:29 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 85's Change in Condition Evaluation (CCE), dated 5/24/25 was reviewed. The CCE indicated, Resident [Resident 85] had seizure 3 times for 30 seconds each, 30 min [minutes] apart. LVN 2 stated Resident 85's first seizure episode started around 1 p.m. The CCE indicated Resident 85's vital signs taken on 5/24/25 at 10:03 a.m. (before seizure). LVN 2 stated FM 2 reported Resident 85 looked flushed. LVN 2 was unable to find documentation of Resident 85's temperature. Resident 85's clinical records were reviewed. LVN 2 stated there was no documentation of Resident 85's vital signs taken after his seizure episodes. LVN 2 stated if there was no documentation, it was not done. During an interview on 5/30/25 at 3:26 p.m. with LVN 3, LVN 3 stated she did not take Resident 85's vital signs after his seizure episode. During a concurrent interview and record review on 5/30/25 at 3:41 p.m. with Director of Nursing (DON), Resident 85's CCE, dated 5/24/25, was reviewed. The CCE indicated there was no documentation of time when each seizure episode began and ended, and vital signs taken after each seizure episode. DON stated there should have been documentation of time for each seizure episode and a set of vitals (vital signs) for the COC (change of condition). During a review of the facility's policy and procedure (P&P) titled, Seizure Precautions, dated 6/1/17, the P&P indicated, Post-Seizure Activity. The resident's vital signs will be obtained and recorded. Documentation. The licensed nurse will record each episode of seizure activity describing: i. Time seizure began. iii. Time seizure ended.