

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  07/08/2025
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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>Based on interview and record review, the facility failed to: 1. Administer narcotic (a strong pain medication) medication according to the physician's orders for one of 10 sampled residents (Resident 1). 2. Reassess and re-evaluate the effectiveness of narcotic medication given for pain for one of 10 sampled residents (Resident 1). These failures had the potential for Resident 1 suffering from uncontrolled pain and/or result in adverse health outcomes. Findings: 1. During a review of Resident 1's admission RECORD (AR), dated 7/9/25, the AR indicated, Resident 1 had diagnoses of Osteomyelitis (an infection of the bone), Complete traumatic amputation (complete removal of a body part due to accident or injury) of the left lower leg, Pain unspecified, Inguinal hernia (a bulge in the groin, area of the body located between the abdomen and the thigh, an area that can be painful). During a review of Resident 1's Order Summary Report (OSR), dated 6/2025, the OSR indicated, Norco (strong narcotic pain medication) 5-325 MG (milligram - a unit of measurement) Give one tablet by mouth every 12 hours as needed for pain scale [a tool used to identify levels of pain, 1-3 is mild pain, 4-6 is moderate pain, and 7-10 is severe pain] 4-10. During a review of Resident 1's MEDICATION ADMINISTRATION RECORD (MAR), dated 6/2025, the MAR indicated, Resident 1 was given Norco 5-325 MG: a. On 6/4/25 with a pain scale of 0. b. On 6/5/25 with a pain scale of 0. c. On 6/10/25 with a pain scale of 0. d. On 6/11/25 with a pain scale of 0. During a concurrent interview and record review on 7/8/25 at 5:33 p.m. with Director of Nursing (DON), Resident 1's MAR dated 6/2025 was reviewed. DON stated Resident 1 was given Norco 5-325 MG out of the parameter (criteria on giving the medication). 2. During a concurrent interview and record review on 7/8/25 at 5:33 p.m. with DON, Resident 1's MAR dated 6/2025 was reviewed. DON stated Resident 1 was given Norco 5-325 MG on 6/1/25, 6/2/25, 6/3/25, 6/4/25, 6/5/25, 6/6/25, 6/7/25, 6/8/25, 6/9/25, 6/10/25, and 6/11/25 but there was no documentation of reassessment of effectiveness for relieving Resident 1's pain. During a review of the facility's policy and procedure (P&amp;P) titled, Pain Management, dated 6/1/17, the P&amp;P indicated, Purpose . To ensure accurate -assessment and management of the resident's pain . The Licensed Nurse will administer pain medication as ordered and document all medication administered on the Medication Administration Record (MAR). The Licensed Nurse will assess the resident for pain and document results on the MAR each shift using the 1-10 pain scale. The Licensed Nurse will document resident's pain and response to interventions in the medical record .</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555902
		If continuation sheet Page 1 of 4

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review the facility failed to follow their policy and procedure on Controlled Medication Storage when: 1. Licensed Vocational Nurse (LVN) 4, LVN 5, and LVN 6 did not immediately report the missing controlled narcotic medications (medications that are highly addictive and have a significant potential for abuse, classified as a controlled substance under the law, meaning its manufacture, distribution, and possession are regulated). 2. LVN 1 did not keep the discontinued 15 tablets of controlled narcotic medications in the medication cart to be counted every change of shift (changing from one work shift to another, e.g., from day shift to night shift). These failures resulted in missing narcotic medications, potential for narcotic diversion (getting legally prescribed narcotics into the wrong hands or using them for the wrong reasons), and had the potential to negatively impact resident's safety. Findings: 1. During an interview on 7/8/25 at 5:05 p.m. with Director of Nursing (DON), DON stated on 6/18/25 it was discovered that four oxycodone (narcotic pain medication), four Percocet (narcotic pain medication), and four Norco (narcotic pain medication) were missing from the facility's E-kit (emergency kit, containing a pre-determined supply of medications, especially controlled substances, for immediate patient needs during emergencies or when standard pharmacy services are unavailable). During a review of the facility document titled Report of Missing Controlled Substances - E-Kit Discrepancy (MCSED), dated 7/9/25, the MCSED indicated, On June 18, 2025, the facility identified a potential discrepancy involving controlled substances missing from the Emergency Drug Kit [E-kit]. The missing medications were reported as follows: Percocet [strong narcotic pain medication] 5/325 mg (milligram-a unit of measurement) - 4 tablets Percocet 10/325 mg - 4 tablets Oxycodone [strong narcotic pain medication] 10 mg - 4 tablets The report originated from a nurse [Licensed Vocational Nurse - LVN 4] who stated that during her shift, she was informed by the outgoing nurse [LVN 5] that the E-kit had already been opened and that these medications were not present. Each nurse [LVN 6] on the preceding shifts reportedly communicated the same information until the one who identified missing medications, she indicated that when she accessed the kit the medications were not present. Despite internal investigation, we have not been able to determine who may have removed the medications. During an interview on 7/9/25 at 10:15 a.m. with Assistant Director of Nursing (ADON), ADON stated on 6/18/25 she was approached by LVN 4 at approximately 9 a.m. and told her there were missing narcotics from the E-kit identified by LVN 5 during shift change (night shift to day shift). ADON stated she told LVN 4 she should not have taken the keys to the medications/narcotics until she reports to the supervisor about the missing narcotics. ADON stated she looked into the E-kit and noted missing narcotics (not specified) that were not accounted for. During an interview on 7/11/25 at 3:54 p.m. with LVN 4, LVN 4 stated LVN 5 (night shift) informed her about the missing narcotics (not specified) from the E-kit on 6/18/25. LVN 4 stated LVN 5 was informed of the missing narcotics by LVN 6 (evening shift 6/17/25). LVN 4 stated despite being told of the narcotics missing, she did not report the issue to the DON and continued on working her shift nor did LVN 5. During an interview on 7/29/25 at 1:45 p.m. with LVN 6, LVN 6 stated she discovered the missing narcotics (not specified) from the E-kit when she went to get narcotic medication for a resident later into her shift on 6/17/25. LVN 6 stated she should have done the E-kit count with LVN 1 to ensure the count was correct. LVN 6 stated she should have reported the missing narcotics to the DON once it was discovered but she did not. During an interview on 8/4/25 at 9:22 a.m. with DON, DON stated on 6/17/25 and 6/18/25, LVN 4, LVN 5, and LVN 6 should not have continued their shift until the missing narcotics were reported. 2. During a review of the facility document titled Facility Report - Missing Controlled Substance (narcotic drugs) (FRMCS), dated 7/11/25, the FRMCS indicated, As part of ongoing investigation and medication audit procedures, it was discovered on July 10, during AM (7:00 a.m. to 3:30 p.m.) shift, that an additional medication card containing 15 tablets of Percocet . along with the associated narcotic count sheet [a form used to track the amount of narcotic is left/used], is missing from Cart 2 [medication cart where resident medications are stored]. The medication had previously been discontinued during the PM shift [3:00 p.m. to 11:30 p.m.] on July 9th. The nurse [LVN 1] . who initiated the discontinuation order reported that he wrapped the narcotic count sheet around the medication card and placed it in the back of the narcotic box on July 9th. He further claims that the medication card and count were verified during a shift change with the oncoming nurse. The oncoming nurse [LVN 7] acknowledged being informed of the medication discontinuation but denies participating in a count or seeing the medication card with the count sheet. The nurse [LVN 1] who handled the discontinued medication and placed it in the box is being terminated for failure to follow proper narcotic handling and</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>Based on interview and record review the facility failed to follow their policy and procedure on Unusual Occurrence Reporting when missing narcotic controlled medications (medications that are highly addictive and has a significant potential for abuse, classified as a controlled substance under the law, meaning its manufacture, distribution, and possession are regulated) was not reported to the California Department of Public Health (CDPH). This failure had the potential for narcotic diversion (the use and/or distribution not intended to) and had the potential for medication errors affecting residents' safety. During an interview on 7/8/25 at 5:05 p.m. with Director of Nursing (DON), DON stated on 6/18/25 it was discovered that four oxycodone (narcotic pain medication), four Percocet (narcotic pain medication), and four Norco (narcotic pain medication) were missing from the E-kit ( emergency kit, containing a pre-determined supply of medications, especially controlled substances, for immediate patient needs during emergencies or when standard pharmacy services are unavailable). During a concurrent interview and record review on 7/8/25 at 5:10 p.m. with Administrator, the facility's policy and procedure (P&amp;P) titled, Unusual Occurrence Reporting, dated 10/1/17 was reviewed. The P&amp;P indicated, The Facility will follow all applicable state and federal laws and regulations regarding the reporting of unusual occurrences. The Facility has a no-retaliation policy toward anyone who makes good faith reports to the Department of Public Health or for any other reporting required by law. The Facility reports the following events by phone and in writing to the appropriate State or Federal agencies . Allegations of misappropriation of resident property; and other occurrences that interfere with facility operations and affect the welfare, safety, or health of residents, employees or visitors. Unusual occurrences are reported to the appropriate agency within 24 hours by telephone and then confirmed in writing . The Facility will provide additional information to the local health officer, or the Department of Public Health as requested. Administrator stated the facility had not reported the narcotic diversion despite what the facility P&amp;P stated.</p>		