

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 07/16/2025
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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on interview and record review, the facility failed to follow their policy and procedure (P&P) on Assessment and Management of Resident Weights for one of five sampled residents (Resident 1) when the registered dietitian (RD)'s recommendations were not communicated to the physician. This failure had the potential to result in Resident 1's weight loss. Findings: During a review of Resident 1's admission Record (AR), dated 7/15/25, the AR indicated, Diagnosis. MILD PROTEIN-CALORIE MALNUTRITION (body has insufficient protein and energy to meet its basic needs). During a review of Resident 1's Weights and Vitals Summary (WVS), dated 7/15/25, the WVS indicated, Resident 1 weighed 126 lbs (pounds - unit of mass) on 6/24/25 and 119 lbs on 7/4/25 (lost seven lbs). During a review of Resident 1's Order Summary Report (OSR), dated 5/27/25, the OSR indicated, Resident 1's diet was no added salt. During a review of Resident 1's OSR, dated 6/11/25, the OSR indicated, Boost (nutritional supplement) . two times a day for Supplement. During a concurrent interview and record review on 7/15/25 at 3:10 p.m. with Director of Nursing (DON), Resident 1's Nutrition note (NN), dated 6/20/25 was reviewed. The NN indicated, the RD recommended liberalizing (tailored to a person's preferences and needs) Resident 1's diet and discontinuing no added salt diet. DON stated she was unable to find documentation the RD's recommendation to liberalize Resident 1's diet was carried out. DON stated any recommendations from the RD were supposed to be communicated to the physician for approval. During a concurrent interview and record review on 7/15/25 at 3:39 p.m. with Assistant Director of Nursing (ADON), Resident 1's NN, dated 6/26/25 was reviewed. The NN indicated, the RD recommended increasing the frequency of Boost from twice a day to three times a day. ADON stated the RD's recommendation to increase Boost was not carried out. During a concurrent interview and record review on 7/15/25 at 4:37 p.m. with DON, the facility's P&P titled, Assessment and Management of Resident Weights, dated June 2017 was reviewed. The P&P indicated, The licensed nurse will notify the physician of the dietitian's recommendations and notify the family/health care decision maker of the weight change, as indicated. E. If the physician does not implement the dietitian's recommendations they will document the rationale for non-implementation in the medical record. i. The licensed nurse will document physician's refusal and communicate this information to the DNS for follow-up on the 24 hour Report. DON stated the P&P was not followed.</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 1