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	08/06/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to implement the care plan (is a comprehensive, personalized document that outlines the specific needs of an individual requiring care, detailing the type of support, how it will be provided, and the goals of the care) for two of three sampled residents (Resident 1 and Resident 2) when: 1.Resident 1 was not repositioned every two hours. This failure had the potential for Resident 1 to develop pressure injury (localized damage to the skin and underlying soft tissue usually over a bony prominence). 2.Resident 2 was not supervised during a meal. This failure had the potential for Resident 2 not to consume the proper nutrition and had the potential for choking. Findings: 1. During a review of Resident 1's Care Plan (CP), dated 6/28/25, the CP indicated, [Resident 1] has altered skin integrity related to pressure injury/wound (localized damage to the skin and underlying soft tissue usually over a bony prominence) Contributory factors: admitted with pressure injury Re-opened pressure injury to sacrococcyx [end of spine, tailbone-two set of bone that form the tailbone] extending to left and right buttock, turn and reposition every 2 hours and PRN (as needed).During an observation on 7/21/25 at 10:46 a. m. at the nurses' station 1, Resident 1 was observed in his wheelchair sitting flat on his buttocks at a 45-degree angle (position of resident lies on the back with pressure is concentrated on the buttocks because the resident's weight is shifted onto their tailbone and buttock regions).During a concurrent observation and interview, on 7/21/25 at 1:32 p.m. in Resident 1's room, with Certified Nursing Assistant (CNA) 2, Resident 1 was observed sitting flat on his buttocks in his wheelchair at a 45-degree angle. CNA 2 stated Resident 1 had previously had a pressure injury and had to be repositioned every two hours. CNA 2 stated she has had Resident 1 since 11a.m. CNA 2 stated Resident 1 was still in the same position sitting in wheelchair.During a review of Resident 1's Minimum Data Set (MDS-comprehensive assessment tool), dated 5/29/25, the MDS indicated Resident 1 is dependent (staff does all the effort) with transfers and mobility. During a concurrent interview and record review, on 7/21/25 at 2:37 p.m. with Director of Nursing (DON). Resident 1's CP dated 6/28/25, was reviewed. DON stated Resident 1 had a history of pressure injury and the CP indicated Resident 1 was to be turned and reposition every two hours. 2. During a review of Resident 2's CP dated 6/15/25, the CP indicated, Nutritional Problems, [Resident 2] required supervision and assistance with all meals. During a review of Resident 2's CP dated 1/23/25, the CP indicated, [Resident 2] has behavior of feeding other resident's [sic], Assign a staff member to be present during mealtimes to offer redirection if the patient attempts to feed others.During an observation on 7/21/25 at 12:21p.m. in Resident 2 and Resident 3's room, Resident 3 was sitting up on bed eating, with meal tray at her bedside table. Resident 2 was sitting on the side of her bed eating her meal, there were no staff were present in the room to monitor Resident 2. During a concurrent observation and interview, on 7/21/25 at 12:42 p.m. in Resident 2's room with CNA 1, Resident 2 was eating by herself in her room. CNA 1 stated Resident 2 needed encouragement and cues to focus on eating. CNA 1 stated there were no staff present in Resident 2 and Resident 3's room, and Resident 2 still had her meal tray on her bedside table and was still eating her meal. CNA 1 stated she was not sure if Resident 2 was supervised for her meal. CNA 1 stated usually the CNA on the floor should help. During an interview on 7/21/25 at 2:12 p.m. with DON, DON stated Resident 2 likes to feed people and for residents with swallowing problems, this could be a safety issue.During a review of the facility's Policy and Procedure (P&P) titled, Care Planning, dated 10/24/22, the P&P indicated, II. The Care Plan serves as a course of action where the resident (resident's family and or guardian or other legally authorized representative). Resident's Attending Physician, and IDT (Interdisciplinary Team- team of healthcare professionals with various areas of expertise who work together to improve patient safety and outcomes) work to help the resident move toward resident -specific goals that address the resident's medical, nursing, mental and psychosocial needs. IX. Each resident Comprehensive Care Plan will describe the following: A. Service that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.

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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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to notify the physician of a change in condition and administer medication according to the physician's order for one of three sampled residents (Resident 1) when Resident 1 was having continuous loose stools/diarrhea. This failure had the potential for Resident 1 losing three lbs. (pounds-weight measurement) weight in one week and potential for adverse health outcomes.Findings:During a review of Resident 1's Plan of Care (PC-is a comprehensive, personalized document that outlines the specific needs of an individual requiring care, detailing the type of support, how it will be provided, and the goals of the care), dated 6/13/25, the PC indicated, [Resident1] has dehydration or potential fluid deficit r/t (related to) new GT (gastrostomy tube feeding- where nutrition and/or fluids are delivered directly into the stomach through a tube inserted into the abdomen) feeding and GI infection (gastrointestinal infection - is an inflammation or irritation of the digestive tract, often caused by bacteria, viruses, or parasites. Administer medications as ordered. Monitor/document for side effects and effectiveness. Notify physician if persistent symptoms of diarrhea, nausea/vomiting unresolved past 48 hours. During a review of Resident 1's PC dated 6/30/25, the PC indicated, The resident [1] has diarrhea r/t [related to] x [times] 4 loose stools with foul odor. Intervention: Give anti -diarrheal medications as ordered. Monitor intake and output.During a review of Resident 1's Medication Administration Record (MAR),dated June 2025, the MAR indicated, Imodium A-D Oral Tablet 2 MG (Milligram- unit of measure) . Give 2 mg via G-Tube every 6 hours as needed for loose stools -Start Date- 06/30/2025 2100 [9 p.m.]-D/C [discontinued] Date-07/1/2025 1023 [10:23 a.m.] The MAR indicated there was no Imodium administered on 6/30/25.During a review of Resident 1's Documentation Survey Report (DSR), dated July 2025, the DSR indicated the following:On 7/1/25 for the day shift, Resident 1 had a medium loose/diarrhea stool.On 7/1/25 for the evening shift, Resident 1 had a large loose/diarrhea stool.On 7/1/25 for the night shift, Resident 1 had a medium loose/diarrhea stool.On 7/2/25 for the evening shift, Resident 1 had a medium loose/diarrhea stool.On 7/2/25 for the evening shift, Resident 1 had a medium loose/diarrhea stool.On 7/2/25 for the night shift, Resident 1 had a large loose/diarrhea stool.On 7/3/25 for the night shift, Resident 1 had a large loose/diarrhea stool.On 7/4/25 for the evening shift, Resident 1 had a large loose/diarrhea stool.On 7/5/25 for the day shift, Resident 1 had a large sized loose/diarrhea stool.On 7/5/25 for the evening shift, Resident 1 had a large loose/diarrhea stool.On 7/5/25 for the night shift, Resident 1 had a large loose/diarrhea stool.On 7/6/25 for the evening shift, Resident 1 had a large loose/diarrhea stool.On 7/7/25 for the evening shift, Resident 1 had a large loose/diarrhea stool.On 7/7/25 for the evening shift, Resident 1 had a large loose/diarrhea stool.On 7/7/25 for the evening shift, Resident 1 had a large loose/diarrhea stool.On 7/8/25 for the evening shift, Resident 1 had a large loose/diarrhea stool.On 7/8/25 for the night shift, Resident 1 had a large loose/diarrhea stool.On 7/8/25 for the night shift, Resident 1 had a small loose/diarrhea stool.On 7/10/25 for the evening shift, Resident 1 had a large loose/diarrhea stool.On 7/10/25 for the evening shift, Resident 1 had a medium loose/diarrhea stool.On 7/11/25 for the day shift, Resident 1 had a medium loose/diarrhea stool.On 7/12/25 for the day shift, Resident 1 had a large loose/diarrhea stool.On 7/12/25 for the evening shift, Resident 1 had a large loose/diarrhea stool.On 7/12/25 for the night shift, Resident 1 had a large loose/diarrhea stool.On 7/13/25 for the night shift, Resident 1 had a large loose/diarrhea stool.On 7/14/25 for the evening shift, Resident 1 had a large loose/diarrhea stool.On 7/14/25 for the night shift, Resident 1 had a large loose/diarrhea stool.On 7/16/25 for the night shift, Resident 1 had a small loose/diarrhea stool. On 7/17/25 for the evening shift, Resident 1 had a large loose/diarrhea stool.On 7/17/25 for the evening shift, the DRS indicated Resident 1 had a medium loose/diarrhea stool.On 7/17/25 for the night shift, the DRS indicated Resident 1 had a large loose/diarrhea stool.On 7/18/25 for the evening shift, Resident 1 had a large loose/diarrhea stool.On 7/18/25 for the night shift, Resident 1 had a large loose/diarrhea stool.On 7/19/25 for the evening shift, Resident 1 had a medium loose/diarrhea stool.On 7/19/25 for the night shift, Resident 1 had a large loose/diarrhea stool.On 7/20/25 for the day shift, Resident 1 had a small loose/diarrhea stool.On 7/20/25 for the evening shift, Resident 1 had a large loose/diarrhea stool.During a review of Resident 1's Weight Summary (WS), dated July of 2025, the WS indicated Resident 1 weighted 135 pounds on 7/1/25 and 132 pounds on 7/8/25 (three pound weight loss in one week).During a review of Resident 1's Change of Condition (COC), dated 7/9/25, the COC indicated, On g-tube feeding, frequently has diarrhea . Resident has lost 3 lbs a weekDuring a review of Resident 1's PC dated 7/9/25, the PC indicated, (Resident 1) has weight loss of 3 lbs in one week. During an interview on 8/6/25 at 11:44 a.m. with Licensed Vocational Nurse