| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555902 | A. Building<br>B. Wing | 09/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Height Street Skilled Care | 1611 Height Street<br>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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a sanitary environment for two of three residents (Resident 1 and Resident 2) when:Resident 1's bathroom had a foul smell. The bathroom tiles in three of four shower rooms used by Resident 2 and other residents were not cleaned.These failures had the potential for unpleasant experience for Resident 1 and Resident 2.Findings:1. During a concurrent observation and interview on 9/3/25 at 10:40 a.m. with Resident 1 in his room, Resident 1 was in his bed facing the bathroom. Resident 1 stated the bathroom had a strong foul and unpleasant smell. The bathroom smelled of urine and bleach like smell.During a concurrent observation and interview on 9/3/25 at 10:55 a.m. with Housekeeping Staff (HS), HS entered Resident 1's bathroom and stated the smell was not pleasant. HS stated another resident used to urinate on the floor in that bathroom and housekeeping was having a difficult time removing the urine odor.2. During an interview on 9/3/25 at 11:10 a.m. with Resident 2 in her room, Resident 2 stated the shower rooms were soiled (not cleaned) and stated had disgusted her.During a concurrent observation and interview on 9/3/25 at 11:15 a.m. with Housekeeping Supervisor (HSUP), HSUP stated there were four resident shower rooms in the facility. The tiles in Shower room [ROOM NUMBER], Shower room [ROOM NUMBER], and Shower room [ROOM NUMBER] had dark stains. HSUP stated the dark stains were buildup from steam, and that staff should wash the tiles and remove them.During a review of the facility's policy and procedure (P&P) titled, Housekeeping - General, dated the August 16, 2023, the P&P indicated, All room of the Facility are kept clean and as free as possible of germs and other contaminating agents at all times, while maintaining a pleasant and homelike atmosphere for our residents. |

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 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely develop a baseline care plan with fall prevention interventions for two of three residents (Resident 1 and Resident 4) who were high risk for falls. This failure had the potential to place Resident 1 and Resident 4 at risk for falls and injury.Findings:During a review of Resident 1s admission Record (AD), undated, the AD indicated, Resident 4 was admitted on [DATE] with diagnoses including muscle weakness and abnormalities of gait and mobility.During a review of Resident 1's Assessment Outcomes Record (AOR), dated [DATE], the AOR indicated, Resident 1's fall risk assessment score of 60 (scores of 45 or higher indicate high fall risk).During a review of Resident 1's Care Plan Report (CPR), undated, the CRP indicated a fall prevention care plan was first created for Resident 1 on [DATE], 26 days after his admission.During a review of Resident 4's AD, undated, the AD indicated, Resident 4 was admitted on [DATE] and had diagnoses including Alzheimer's disease (memory loss), muscle weakness, and abnormalities of gait and mobility.During a review of Resident 4's AOR, dated [DATE], the AOR indicated, Resident 4 had a fall risk assessment score of 50 (scores of 45 or higher indicate high fall risk).During a review of Resident 4's CPR, undated, the CRP indicated, a fall prevention care plan was first created for Resident 4 on [DATE], seven days after admission.During a concurrent interview and record review on [DATE] at 1:55 p.m. with the Director of Nursing (DON), DON stated Resident 1 and Resident 4 were assessed to be at a high risk for falls upon admission but no baseline care plan with fall prevention interventions was developed for them. DON stated a fall prevention care plan was first created for Resident 1 on [DATE], 26 days after admission, and for Resident 4 on [DATE], seven days after admission. DON stated baseline care plans addressing residents' needs should be created within 72 hours of admission.During a review of the facility's policy and procedure (P&P) titled, Care Planning, dated the [DATE], the P&P indicated, The Facility will develop a person-centered Baseline Care Plan for each resident within 48 hours of admission.During a review of the facility's policy and procedure (P&P) titled, Fall Management Program, dated the [DATE], the P&P indicated, The Nursing Staff will develop a plan of care specific to the resident's needs with interventions to reduce the risk of fall. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement the fall prevention intervention of keeping the bed in the low position for one of three residents (Resident 4) who was high risk for falls. This failure had the potential to place Resident 4 at the risk for falls and injury.Findings:During a review of Resident 4's admission Record (AD), undated, the AD indicated, Resident 4 was admitted on [DATE] and had diagnoses including Alzheimer's disease (memory loss), muscle weakness, abnormalities of gait and mobility and pain.During a review of Resident 4's Assessment Outcomes Record (AOR), dated [DATE], the AOR indicated, Resident 4 had a fall risk assessment score of 50 (scores of 45 or higher indicate high fall risk).During a review of Resident 4's Care Plan Report (CPR), dated [DATE], the CRP indicated, The resident needs a safe environment with. the bed in the low position.During a concurrent observation and interview on [DATE] at 10:15 a.m. in Resident 4's room, with Family Member (FM) 4, Resident 4 was lying in bed on a low bed (a specialty bed that lowers close to the floor with the purpose of mitigating the risk of injury in case of a fall from the bed and is used for residents at risk for falls). During a concurrent interview, FM 4 stated he was concerned about Resident 4 falling from the bed because Resident 4 attempted to get out of bed unassisted. Resident 4's bed was not in the low position, at the height of a regular bed.During a concurrent observation and interview on [DATE] at 10:16 a.m. with Licensed Nurse (LN) C stated Resident 4's bed was not at the low position. LN C then lowered Resident 4's bed at least one foot closer to the floor. LN C stated Resident 4 was at risk for falls and his bed should always be kept in the low position.During an interview on [DATE] at 1:55 p.m. with the Director of Nursing (DON), DON stated Resident 4's bed should be kept at the low position according to his fall prevention care plan.During a review of the facility's policy and procedure (P&P) titled, Fall Management Program, dated the [DATE], the P&P indicated, Universal Fall Prevention Measures for all Residents.place bed in lowest position. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to manage the pain of one of three residents (Resident 4) when Resident 4 reported pain to Certified Nursing Assistant (CNA) A and CNA B but did not inform the Licensed Nurse (LN) C. This failure had the potential for Resident 4 suffering in pain.<br>Findings:During a review of Resident 4's admission Record (AD), undated, the AD indicated Resident 4 was admitted on [DATE] and had diagnoses including Alzheimer's disease (memory loss), muscle weakness, abnormalities of gait and mobility, and pain.During a concurrent observation and interview on 9/3/25 at 10:15 a.m. in Resident 4's room, Resident 4 was lying in bed with Family Member (FM) 4 at bedside. FM 4 stated Resident 4 had dementia (memory loss) but was able make needs known.During an observation on 9/3/25 at 11:40 a.m. in Resident 4's room, CNA A and CNA B were providing care to Resident 4. During care, Resident 4 reported to CNA A and CNA B that he had pain in his arms. CNA A and CNA B left the room, and there was no pain relief interventions were provided to Resident 4.During a concurrent observation and interview on 9/3/25 at 12:20 p.m. (40 minutes later) with LN C in the hallway in front of Resident 4's room, LN C stated she was Resident 4's nurse and that no one had informed her Resident 4 had pain. LN C went to Resident 4's room and asked Resident 4 if he was in pain. Resident 4 reported pain in his arms rated level five (on zero to 10 scale where zero is no pain and 10 is the worst pain).During an interview on 9/3/25 at 1:55 p.m. with the Director of Nursing (DON), DON stated CNAs should immediately inform the resident's LN whenever a resident reports pain. DON stated the LN should then immediately assess the resident for pain and provide appropriate pain interventions.During a review of the facility's policy and procedure (P&P) titled, Pain Management, dated the June 1, 2017, the P&P indicated, Facility staff is responsible for helping the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain. |