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	04/27/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to:1. Maintain an environment free of accident hazards for four of 41 sampled residents (Resident 86, Resident 110, Resident 111, Resident 85) when Resident 86, Resident 110, Resident 111, Resident 85 were allowed to keep cigarette lighters in their rooms unsecured. This failure had the potential for residents who wandered to access the cigarette lighters and potentially start fires in the facility and jeopardizing the safety of all residents, visitors and staff members. 2. Follow their policy and procedure (P&P) titled, Elopement [when a resident leaves the facility premises without staff knowledge or permission] and Wandering [when a resident walks around aimlessly, unsupervised] when:a. The facility did not ensure wander guards (wearable device used to detect the resident's proximity to exit points) were checked weekly for placement, testing, and expiration dates for two of two sampled residents (Resident 92 and Resident 96). This failure had the potential to place Resident 92 and Resident 96 at increased risk for elopement.b. The facility did not monitor wandering patterns as indicated in the care plan for one of two sampled residents (Resident 92) who was at risk for elopement. This failure resulted in Resident 92 walking out to the facility parking lot unsupervised. Findings: 1. During a concurrent observation and interview on [DATE] at 12:11 p.m. with Social Service Director (SSD) in the outside smoking area, Resident 86 was sitting in her wheelchair, and SSD was sitting on a chair. Resident 86 had a cigarette lighter in her right hand. SSD removed the smoking apron and stated Resident 86 liked to keep her cigarette lighter and cigarettes with her all the time. During a concurrent observation and interview on [DATE] at 12:20 p.m. with SSD in Resident 86's room, Resident 86 had a red multi-purpose lighter on her wheelchair. SSD stated Resident 86 informed her that a male smoker resident gave her the multi-purpose red lighter. SSD stated Resident 86 had her cigarette lighter and cigarettes in her clear bag which she kept in her room unsecured. During an interview on [DATE] at 12:33 p.m. with SSD, SSD stated there were three more residents keeping their cigarettes and cigarette lighters with them. During a concurrent observation and interview on [DATE] at 12:35 p.m. with Resident 110 in Resident 110's room, there was a cigarette and a cigarette lighter in a plastic container in the nightstand drawer. Resident 110 stated there was no locked drawer to keep the cigarette lighter secured. During a concurrent observation and interview on [DATE] at 12:36 p.m. with Resident 111 in Resident 111's room, there was a cigarette and a cigarette lighter in a plastic container in the nightstand drawer. Resident 111 stated there was no locked drawer to keep the cigarette lighter secured. Resident 111 stated sometimes he would light cigarettes for other residents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 12:38 p.m. with Resident 85 in Resident 85's room, there was a cigarette and cigarette lighter in a plastic container on top of a cardboard box next to his bed and night stand drawer. Resident 85 stated there was no locked drawer to keep the cigarette lighter secured. During a concurrent interview and record review on [DATE] at 1:57 p.m. with Assistant Director of Nursing (ADON), Resident 86's Medical Record (MR), undated was reviewed. The MR indicated Resident 86 had her last smoking assessment completed on [DATE]. ADON stated smoking assessments were supposed to be completed quarterly. ADON stated there was no care plan to keep the cigarette lighter at bedside. During a concurrent interview and record review on [DATE] at 1:58 p.m. with ADON, Resident 110's MR, undated was reviewed. ADON stated there was no care plan to keep cigarette lighters and cigarette at bedside. During a concurrent interview and record review on [DATE] at 1:59 p.m. with ADON, Resident 111's MR, undated was reviewed. ADON stated there was no care plan to keep cigarette lighters and cigarette at bedside. During a concurrent interview and record review on [DATE] at 2 p.m. with ADON, Resident 85's MR, undated was reviewed. ADON stated there was no care plan to keep cigarette lighters and cigarette at bedside. During a review of facility's policy and procedure (P&P) titled, Smoking, dated [DATE], the P&P indicated, To respect resident/employee choice to smoke and to maintain a safe healthy environment for both smokers and non-smokers.Policy.IV. Residents who want to smoke will be assessed for their ability to smoke safely prior to being allowed to smoke independently in these areas.Procedure I. Smokers shall be identified at the time of admission.II. A licensed Nurse will complete the Smoking Assessment for residents who wish to smoke in PointClickCare. A. All smokers shall be assessed related to smoking safety at the time of admission and then at last quarterly as outlined by OBRA assessment timeframe.X. All smoking materials will be stored in a secure area to ensure they are kept safe. Based on the individual resident's Smoking Assessment, Facility Staff shall determine the most appropriate method of secure storage. A. Examples of secure areas include but are not necessarily limited to: i. Locked drawers or cupboards in the resident's room. ii. Locked box in a resident's room. Iii. Labeled box in a locked medication room and clearly identified with the resident's name and room number.XV. Residents are strongly encouraged not to share their smoking materials with any other resident, staff, family, and/or visitor(s). 2. a. During a review of Resident 96's admission Record (AR), dated [DATE], the AR indicated, DIAGNOSIS. UNSPECIFIED DEMENTIA (decline in mental abilities severe enough to interfere with daily life) . SCHIZOPHRENIA (chronic and severe mental disorder that affects how a person thinks, feels, and behaves) . ANXIETY DISORDER (excessive fear or worry that interferes with daily life) . PSYCHOTIC DISORDER (severe mental health condition that causes a person to lose touch with reality) WITH DELUSIONS (false belief that a person holds onto despite clear evidence that it is not true). During a review of Resident 96's Minimum Data Set (MDS – a resident assessment tool), dated [DATE], the MDS indicated on Section C (Cognitive Patterns), Resident 96 had severely impaired daily decision-making skills. The MDS indicated on Section P (Restraints and Alarms), Resident 96 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was using a wander or elopement alarm daily. During a review of Resident 96's Order Summary Report (OSR), dated [DATE], the OSR indicated, Resident to wear wander guard stopwatch to alert staff of leaving unattended. During a review of Resident 96's Nursing Quarterly Assessment (NQA), dated [DATE], the NQA indicated, Resident 96 had an elopement risk score of 9 (at serious risk for elopement). During a review of Resident 92's AR, dated [DATE], the AR indicated, DIAGNOSIS. UNSPECIFIED DEMENTIA. During a review of Resident 92's MDS, dated [DATE], the MDS indicated on Section C, Resident 92 had severely impaired daily decision-making skills. The MDS indicated on Section GG (Functional Abilities), Resident 92 was able to walk at least 150 feet independently. The MDS indicated on Section P, Resident 92 was using a wander or elopement alarm daily. During a review of Resident 92's OSR, dated [DATE], the OSR indicated, Resident to wear wander guard stopwatch to alert staff of leaving unattended. During a review of Resident 92's NQA, dated [DATE], the NQA indicated, Resident 92 had an elopement risk score of 7 (at serious risk for elopement). During a concurrent observation and interview on [DATE] at 4:48 p.m. with DON in Resident 92's room, Resident 92 was not wearing her wander guard and then the ADON walked into Resident 92's room with a new wander guard. DON stated Resident 92's old wander guard was in her office and the wander guard had to be replaced because it had already been expired. During a concurrent observation and interview on [DATE] at 4:50 p.m. with DON in Resident 96's room, Resident 96 was wearing a wander guard with an expiration date of [DATE] on his left ankle. DON stated Resident 96's wander guard was expired and should have been replaced. During a concurrent observation and interview on [DATE] at 4:55 p.m. with DON in DON's office, there was a wander guard with an expiration date of [DATE] on DON's desk. DON stated this was Resident 92's old wander guard. During a concurrent interview and record review on [DATE] at 4:55 p.m. with DON, the facility's Wanderguard Weekly Check Log (WWCL), dated [DATE] was reviewed. The WWCL indicated, Resident 92's wander guard placement and skin were checked weekly. DON stated Resident 92's wander guard was not being checked for expiration date. DON stated Resident 96's wander guard was not being checked weekly for placement, testing and expiration date. DON stated Resident 92's and Resident 96's wander guards should have been checked for placement, testing and expiration date weekly. DON stated if a wander guard was used beyond the expiration date, it would place the resident at risk for elopement because of device failure. During a concurrent interview and record review on [DATE] at 1:03 p.m. with DON, the facility's Wander Management Transmitters (wander guard) User Guide (WMTUG), dated [DATE] was reviewed. The WMTUG indicated, Each transmitter is stamped with a warranty expiration date. WARNING: Using a transmitter beyond the printed expiration date can result in system failure and/or elopement. Weekly Testing The following testing is required for all transmitters in use on residents. 1. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Test the operation of transmitters using the transmitter tester. NOTE: Never take a resident to a door to test their transmitter. 2. Visually inspect transmitters for damage or loose parts. 3. Verify that the warranty expiration date stamped on the transmitter has not expired. If the warranty period has expired, discard and replace the transmitter immediately. 4. Your facility must keep records of test and transmitter inspection. DON stated the WMTUG was not followed. b. During a review of Resident 92's Care Plans (CP), dated [DATE], the CP indicated, Problem. (Resident 92) is an elopement risk/wanderer r/t (related to) Impaired safety awareness. Interventions. Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. During a review of Resident 92's Change in Condition Evaluation (CCE), dated [DATE], the CCE indicated, During shift exchange resident (92) was out in the parking lot Residents (Family Member [FM] 1) brought (Resident 92) in as (FM 1) was arriving at the facility at this time. During an interview on [DATE] at 12:24 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated he was the nurse assigned to Resident 92 on [DATE] morning shift (7 a.m. to 3 p.m.). LVN 3 stated during the change of shift rounds with LVN 2 on [DATE] around 2:50 p.m. to 2:55 p.m., Resident 92 was sitting on her bed in her room. LVN 3 stated he did not remember hearing the wander guard door alarm on [DATE]. LVN 3 stated there was no monitoring done for elopement and wandering for Resident 92. LVN 3 stated there should have been monitoring done for elopement and wandering for Resident 92 because they did not want Resident 92 to get lost and to wander outside the facility, placing her at risk for injuries and at risk for falls. During an interview on [DATE] at 3:03 p.m. with LVN 2, LVN 2 stated he was the nurse assigned to Resident 92 on [DATE] evening shift (3 p.m. to 11:30 p.m.). LVN 2 stated during the change of shift rounds with LVN 1 on [DATE], LVN 2 did not see Resident 92 in her room. LVN 2 stated on [DATE] at around 2:55 p.m., he saw Resident 92 walking in the hallway by the shower room towards the kitchen. LVN 2 stated after the change of shift rounds with LVN 1 on [DATE], LVN 2 was at the nurses station 2 when he heard the wander guard door alarm coming from the front lobby. LVN 2 stated he went to the front lobby and he recalled seeing nurses at station 1 (near the front lobby) when the wander guard door alarm was ringing. LVN 2 stated he saw Resident 92 and FM 1 walking at the facility parking lot back into the facility. LVN 2 stated he did not notice any other staff members attempt to search for Resident 92. LVN 2 stated he did not announce the code for a missing resident, and he did not hear anybody announce the code for a missing resident. During an interview on [DATE] at 10:56 a.m. with FM 1, FM 1 stated he found Resident 92 in the facility parking lot walking by herself. FM 1 stated when he brought Resident 92 back into the facility, the door alarm was ringing. FM 1 stated when they walked past the front lobby, he saw a male staff approaching them and the male staff turned off the door alarm. FM 1 stated he saw there were nurses at the nurses' station near the front lobby and nobody at the nurses' station asked him what happened. FM 1 stated he talked to the male nurse assigned to Resident 92 (LVN 2) and LVN 2 told him he did not know Resident 92 was gone because LVN 2 just got to the facility. During an interview on [DATE] at 11:17 a.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated she was the CNA assigned to Resident 92 on [DATE] evening shift (2 p.m. to 10 p.m.). CNA 3 stated she was not aware Resident 92 walked out to the facility parking lot by herself. CNA 3 stated she did not remember hearing the wander guard door alarm on [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 1:11 p.m. with DON, Resident 92's MR, undated were reviewed. The MR indicated, there was no documentation Resident 2's behavior pattern of wandering was monitored. DON stated there should have been monitoring of Resident 92's wandering to monitor if the behavior had increased or if there would be changes. During an interview on [DATE] at 1:15 p.m. with DON, DON stated on [DATE] when Resident 92 was found at the facility parking lot by FM 1, the facility staff's response time to the wander guard door alarm should have been more immediate. DON stated when the facility staff would hear the wander guard door alarm, they were expected to check all the exit doors, check for missing residents especially Resident 92 because she was the only resident with a wander guard who could walk. DON stated when a resident was identified missing, code green should have been announced. DON stated code green was not announced on [DATE] when Resident 92 got out of the facility. During a concurrent interview and record review on [DATE] at 1:15 p.m. with DON, the facility's P&P titled, Elopement and Wandering, dated [DATE] was reviewed. The P&P indicated, Purpose To enhance the safety of residents of the Facility. The resident's risk for elopement and preventative interventions will be documented in the resident's medical record. Response to Resident Elopement A. The facility Staff member who finds that a resident is missing will alert Facility Staff. B. The Charge Nurse will call CODE [NAME] and organize a search. Facility Staff will search areas of the Facility, including common areas, bathrooms, showers, outside areas. DON stated the P&P was not followed.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to review and accurately complete the annual Pre-admission Screening Assessment and Resident Review (PASRR-federal requirement to help ensure that individuals are not incorrectly placed in nursing homes or long-term care instead of a psychiatric setting) for one of 18 sampled residents (Resident 38). This failure had the potential for Resident 38 to be placed in an inappropriate setting and not receive required services.Findings:During a review of Resident 38's admission Record (AR), dated 5/10/25, the AR indicated, Resident 38 has diagnosis of Dementia (a decline in mental ability severe enough to interfere with daily life, caused by physical changes in the brain), Schizophrenia (a chronic, severe brain disorder that causes individuals to interpret reality abnormally, characterized by disruptions in thought, perception, and emotion), and Auditory Hallucinations (the perception of hearing sounds-such as voices, music, or buzzing-in the absence of any external physical stimulus).During a concurrent interview and record review on 4/22/26 at 9:16 a.m. with Director of Nursing (DON), Resident 38's PASRR dated 2/11/25 was reviewed. The PASRR letter indicated, If the individual remains in the NF [Nursing Facility] longer than 30 days, the facility must resubmit a new Level I Screening as a Resident Review on the 31st day. DON stated there should have been new PASRR submitted after 3/12/25.During a review of the facility's policy and procedure (P&P) titled, Pre-admission Screening and Resident Review (PASRR), dated 7/1/23, the P&P indicated, To ensure that all Facility applicants are screened for mental illness and/or intellectual disability and to ensure coordination with the appropriate state agencies, if indicated.

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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 interview and record review, the facility failed to communicate with methadone (medication used to help people reduce or quit opiates [pain medication]) outside clinic when one of one sampled resident (Resident 86) was admitted to the hospital for overdose. This failure had the potential not to meet resident needs.Findings:During a concurrent interview and record review on 4/22/26 at 9:31 a.m. with Director of Nursing (DON) Resident 86's Transfer Form, dated 11/22/26 was reviewed. The Transfer Form indicated Resident 86 was transferred to hospital for low oxygen saturation (level of oxygen in blood), and oversedation. DON stated resident was transferred to hospital and Resident 86 had order for Narcan (to rapidly reverse an opioid overdose) and it was not administered.During a review of Resident 86's hospital discharge paperwork (HDP) dated 11/23/25, the HDP indicated, Diagnosis: 1. Accidental methadone overdose.During an interview on 4/23/26 at 1:20 p.m. with DON, DON stated there was no documentation indicating that the Methadone clinic was notified about Resident 86's condition. DON stated facility just set up a new system to communicate with the Methadone Clinic.During a review of facility's policy and procedure (P&P) titled, Referrals to Outside Services, dated 1/1/2025, the P&P indicated, II. The Director of Social Services is responsible for locating agencies and programs that meet the needs of residents, facilitating the execution of service provider contracts, and referring residents to existing contracted providers.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure effective communication for one of one sampled resident (Resident 3) with a hearing deficit, when a communication board was not utilized. This failure resulted in Resident 3's inability to understand the information conveyed.Findings: During a review of Resident 3's Diagnosis Report (DR), dated [DATE], the DR indicated, Resident 3 had a diagnosis of Conductive Hearing Loss [sound is unable to reach the inner ear due to blockages or structural deformities], Bilateral [both ears].During a review of Resident 3's Minimum Data Set (MDS-resident assessment tool), dated [DATE], the MDS indicated, Resident 3 had a Brief Interview for Mental Status (BIMS, 13 to 15 indicates intact cognition [thinking/memory], 8-12 indicates moderate impairment, 0-7 indicated severe impairment) score of 14.During an interview on [DATE] at 8:46 a.m. the surveyor utilized a whiteboard to communicate with Resident 3 due to Resident 3's hearing impairment. Resident 3 was able to understand and respond appropriately by writing their response on the whiteboard. When Resident 3 was asked if staff communicate with him using a whiteboard, Resident 3 responded in writing, No. Resident 3 was asked if he understands what staff are saying when they come into his room. Resident 3 responded in writing, No, they just talk and I can't hear them. Resident 3 was asked if this bothered him and how it made him feel. Resident 3 responded in writing, Yes and Mad.During an observation on [DATE] at 8:55 a.m. in Resident 3's room a staff member walked into the room and verbally told Resident 3 she would come back to change him when he was finished speaking to surveyor. Staff members used hand gestures like she was rubbing her arms and then left the room.During an interview on [DATE] at 8:56 a.m. Resident 3 was asked in writing if he understood what the staff member had verbally communicated to him. Resident 3 wrote No.During an observation on [DATE] at 11:27 a.m. in Resident 3's room, Certified Nursing Assistant (CNA) 1 brought Resident 3 an extra blanket. CNA 1 verbally asked Resident 3, Do you want the blanket one sided or double sided? Resident 3 gave a thumbs up. CNA 1 verbally asked Resident 3, Is that better? Resident 3 did not respond. CNA 1 verbally asked Resident 3, Are you ok? Resident 3 did not respond.During an interview on [DATE] at 11:29 a.m. Resident 3 was asked in writing if he had understood what CNA 1 verbally told him. Resident 3 responded in writing, No. Resident 3 wrote he wanted staff to use the whiteboard to communicate with him.During an observation on [DATE] at 11:39 a.m. in Resident 3's room, CNA 2 walked into the room and verbally asked Resident 3 if he was ready to get up for lunch.During an interview on [DATE] at 11:40 a.m. with Resident 3, Resident 3 was asked in writing if he understood what CNA 2 had verbally told him. Resident 3 wrote; no, he did not understand CNA 2.During an observation on [DATE] at 11:45 a.m. in Resident 3's room, CNA 2 entered Resident 3's room and verbally informed him that she was going to clean him up. CNA 2 verbally informed Resident 3 she was going to raise the bed and continued to speak to Resident 3. Resident 3 did not respond to CNA 2.During an observation on [DATE] at 12:03 p.m. in the dining room, Resident 3 was sitting at a table in his wheelchair. Resident 3 did not have a whiteboard or notepad available for communication. During a concurrent interview and record review on [DATE] at 1:50 p.m. with Director of Nursing (DON), Resident 3's Care Plan Report (CPR), dated [DATE] was reviewed. The CPR indicated, [Resident 3] has a communication problem r/t [related to] Hearing deficit, Oral deformity.requires communication board.Interventions.COMMUNICATION: Resident requires a communication board for people to write on as a form of communication.The resident is able to communicate by using communication board, by pointing at yes or no questions or by pointing at what is written on the board.The resident prefers communicating.use communication board). DON stated staff should be using the whiteboard or a note pad to communicate in writing with Resident 3. During a review of the facility's policy and procedure (P&P), titled, Resident Rights, dated [DATE], the P&P indicated, All residents have the right to a (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dignified existence, self-determination and communication.The facility must treat each resident with respect dignity and care for each resident in a manner.that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility will protect and promote the rights of the resident and provide equal access to quality care regardless of diagnosis, severity of condition, or payment source.Procedure.D. Be fully informed and participate in his /her treatment including being fully informed in a language that he or she can understand.During a review of the facility's P&P titled, Deaf or Hearing Impaired Resident Care, dated [DATE], the P&P indicated, To assist the resident in adjusting to the facility, reduce anxiety, and promote resident safety.II. Nursing staff will consider the following methods for communication based on the residents need: A. Pencil and paper.C. Communication Board.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide assistance with activities of daily living (ADL - tasks required for self care such as bathing, eating. dressing, transferring, toileting and continence) for one of 18 sampled residents (Resident 4) when nail care and shaving was not provided to a dependent resident. Findings:During a review of Resident 4's admission Record (AR), dated 2/24/26, the AR indicated, Resident 4 was admitted to the facility on [DATE] with diagnoses including encephalopathy (dysfunction of the brain that alters brain function).During a review of Resident 4's Minimum Data Set (MDS-Resident assessment tool), dated 2/27/26, the MDS Section GG - Functional Abilities indicated, Resident 4 was dependent on staff assistance to complete personal hygiene (shaving, washing hands, fingernail trimming).During a review of Resident 4's Brief Interview for Mental Status (BIMS - cognitive assessment), dated 4/20/26, the BIMS score indicated, Resident 4's score was 9 (moderately impaired).During a review of Resident 4's Activities of Daily Living [ADL] Care Plan, dated 3/18/26, the ADL Care Plan indicated, Resident 4 had an ADL self-care performance deficit related to impaired balance, limited mobility and acute condition.During an observation on 4/20/26 at 9:35 a.m. in Resident 4's room, Resident 4 was lying in bed, awake and alert. Resident 4 opened his mouth and stringy dry saliva was stuck on his top lip and bottom lip and stated thirsty. Resident 4 had a scruffy unshaven beard approximately one quarter inch in length. Resident 4's fingernails on both hands were untrimmed with dark brown debris underneath his fingernails of his right hand.During a concurrent observation and interview on 4/20/26 at 11:05 a.m., in Resident 4's room with Assistant Director of Nursing (ADON), Resident 4 was lying in bed. Resident 4 stated to ADON that he was thirsty and wanted water with ice. ADON stated Resident 4 had untrimmed fingernails with dirt underneath his nails and had unshaven beard. ADON asked Resident 4 if he wanted to be shaved, and Resident 4 stated yes.During a review of the facility's policy and procedure (P&P) titled, Grooming Care of the Fingernails and Toenails dated 1/01/26, the P&P indicated, Nail care is given to clean and keep the nails trimmed.

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	555902	A. Building B. Wing	04/27/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure treatments were administered as ordered by the physician for one of three sampled residents (Resident 6). This failure had the potential to result in Resident 6 developing skin breakdown.Findings:During a review of Resident 6's Nursing Quarterly Assessment (NQA), dated 2/26/26, the NQA indicated, Resident 6 had a Braden Skin Risk Score (used to assess a resident's risk for developing a pressure ulcer [damage to the skin usually over bony areas caused by prolonged pressure]) of 13 (score of 13-14 means at moderate risk for skin breakdown).During a review of Resident 6's Order Summary Report (OSR), dated 4/23/26, the OSR indicated, Resident 6 had a physician order for Calmoseptine ointment (used to protect and heal irritated skin) to be applied on his left and right buttocks, and perineum (area between the genitals and the anus) every two hours for skin maintenance.During a concurrent interview and record review on 4/23/26 at 11:59 a.m. with Treatment Nurse (TN), Resident 6's Treatment Administration Record (TAR), dated April 2026 was reviewed. The TAR indicated, there was no documentation Calmoseptine was administered to Resident 6 on 4/14/26 at 12 p.m., 2 p.m., 8 p.m., 10 p.m. TN stated if there was no documentation on the TAR, the Calmoseptine was not administered. TN stated if the Calmoseptine was not administered as ordered by the physician, it would put Resident 6 at risk for skin breakdown.During a concurrent interview and record review on 4/27/26 at 1:09 p.m. with Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Wound Management, dated 1/1/26 was reviewed. The P&P indicated, A resident who has a wound will receive necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing. Implement a wound treatment per physician's order. DON stated the P&P was not followed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview, and record review, the facility failed to implement a physician order for one of three sampled residents (Resident 10) when a Registered Dietician (RD) consult was not completed. This failure had the potential to negatively impact on Resident 10's nutritional status and overall health.Findings:During a review of Resident 10's Electronic Health Record (EHR), (undated), the EHR indicated, Resident 10 had a significant weight loss (more than 5 percent of body weight) within one month. On 3/1/26 Resident 10's weight was 184 pounds and on 4/3/26 Resident 10's weight was 166 pounds.During a review of Resident 10's Physician Progress Note (PPN), dated 4/6/26, the PPN indicated, The resident has experienced a 2-pound weight loss over the past month and a total of 17 pounds over the past six months.the degree of unintentional weight loss is clinically significant.Assessment and Plan.Order dietary Consult for comprehensive nutritional assessment.During a review of Resident 10's Order Summary (OS), dated 4/6/26, the OS indicated, there was a telephone physician order for an RD consult placed on 4/6/26.During a concurrent interview and record review on 4/22/26 at 10:14 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 10's EHR, (undated) was reviewed. The EHR indicated, Resident 10's most recent RD consult was completed on 8/22/25. LVN 1 stated Resident 10 should have had a RD consult completed for the physician order date 4/6/26. During an interview on 4/22/26 at 10:16 a.m. with Director of Nursing (DON), DON stated the RD should assess the resident within 24 hours of the consult order being placed. During an interview on 4/23/26 at 10:38 a.m. with RD, RD stated when physician's place an order for RD consult, facility staff are to call her to inform her about the consult. RD stated the consult should be completed within 7 days. RD stated there was currently no process in place of who was responsible for informing her of consult orders. RD stated she was not made aware of Resident 10's RD consult order until 4/22/26 by the DON. RD stated she did not complete Resident 10's nutritional assessment until she was notified of the consult on 4/22/26. During a review of the facility's policy and procedure (P&P) titled, Assessment and Management of Resident Weights, dated 1/2025, the P&P indicated, V. Significant Weight Change Management.the DNS [Director of Nursing Services] or licensed nurse will.ii. Notify the physician and dietician of significant weight changes.C. The registered dietician will: i. Complete a nutritional assessment and weight management recommendations in the medical record.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 6) head of bed was elevated to prevent aspiration (when food or liquid enters the airway or lungs instead of going into the stomach) while receiving enteral tube feeding (liquid nutrition is given directly into the stomach through a tube). This failure had the potential to result in serious harm, including aspiration pneumonia (lung infection that occurs when food or liquid enters the lungs), respiratory compromise (lungs unable to work well enough and can make breathing difficult) and death.Findings:During an observation on 4/21/26 at 3:37 p.m. in Resident 6's room, Resident 6 was lying in bed, with the head of bed (HOB) elevated at a 15-degree angle. Licensed Vocational Nurse (LVN) 2 was at bedside. LVN 2 connected Resident 6 to his enteral feeding. LVN 2 set the feeding pump rate to administer 60 milliliters (ml) per hour. LVN 2 left Resident 6's room after starting Resident 6's enteral feeding.During a concurrent observation and interview on 4/21/26 at 3:39 p.m. with LVN 2 in Resident 6's room, Resident 6 was lying in bed with the HOB elevated at a 15-degree angle. Glucerna (nutritional formula) was connected to Resident 6's enteral feeding pump and was being administered at a rate of 60 ml per hour. LVN 2 stated he was not sure how elevated Resident 6's HOB was. LVN 2 stated there was nowhere on Resident 6's bed to check the elevation. LVN 2 stated Resident 6's HOB should have been elevated to a 90-degree angle while he was receiving enteral feeding.During a concurrent observation and interview on 4/21/26 at 3:40 p.m. with Registered Nurse (RN) 1 in Resident 6's room, Resident 6 was lying in bed with the HOB elevated at a 15-degree angle. RN 1 stated Resident 6's HOB was not elevated properly to prevent aspiration. RN 1 stated the HOB was at an angle below 30 degrees. RN 1 stated Resident 6's HOB should have been elevated to a 50-degree angle during enteral feedings.During a review of Resident 6's Order Review History Report (ORHR), dated 4/22/26, the ORHR indicated, Glucerna 1.5 @ [at] 60 ml [per] hour x[times] 20 hours via enteral feeding pump. Start at 12 noon and stop @ 8 am.During a review of Resident 6's ORHR, dated 4/22/26, the ORHR indicated, Resident 6 had an active physician order dated 6/12/25 to Keep HOB 30-45 degree elevated or as tolerated to prevent aspiration.During a review of Resident 6's Care Plan Report (CPR), dated 6/13/25, the CPR indicated, [Resident 6] requires tube feeding r/t [related to] Dx [diagnosis] of Dysphagia [difficulty swallowing food].Interventions.The resident needs HOB elevated 45 degrees during and 30 minutes after tube feed.Policy and procedure requested for enteral tube feedings on 4/22/26, facility failed to provide.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to administer medications according to physician orders for one of seven sampled residents (Resident 2) when Resident 2 had an order for the administration of one inhalation (drawing the medication into the lungs) of Breo Ellipta Inhalation Aerosol Powder (a medication to treat inflammation of the lungs) 200-25 MCG (micrograms-unit of measurement)/ACT (actuation - refers to a single spray, puff, or activation of an inhaler) and Resident 2 inhaled two doses of the medication. This failure resulted in Resident 2 receiving twice ordered the dose of Breo Ellipta Inhalation Aerosol Powder 200-25 MCG/ACT and placed Resident 2 at risk of medication overdose. Findings:During a concurrent observation and interview on 4/21/26 at 9:05 a.m. with Registered Nurse (RN) 2 in Resident 2's room, RN 2 stated she was going to administer the Breo Ellipta Inhalation Aerosol Powder 200-25 MCG/ACT to Resident 2. RN 2 removed the Breo Ellipta Inhalation Aerosol Powder 200-25 MCG/ACT inhaler from the box and handed it to Resident 2. Resident 2 inhaled one dose. RN 2 directed Resident 2 to inhale a second dose. Resident 2 inhaled a second dose. RN 2 returned the Breo Ellipta Inhalation Aerosol Powder 200-25 MCG/ACT inhaler to the medication cart. The administration instructions attached to Resident 2's Breo Ellipta Inhalation Aerosol Powder indicated one puff inhale orally daily (one time a day).During an interview on 4/21/26 at 10:05 a.m. with Director of Nursing (DON), DON provided Resident 2's Order Summary Report (OSR) (a list of Resident 2's active physician orders) printed 4/21/26 at 9:51 a.m. and stated it contained Resident 2's current physician medication orders.During a review of Resident 2's OSR printed 4/21/26 at 9:51 a.m., the OSR indicated, Breo Ellipta Inhalation Aerosol Powder Breath Activated 200-25 MCG/ACT . 1 puff inhale orally one time a day . Order Date 3/11/26 . Order Status Active. During a review of facility policy and procedure (P&P) titled, Medication - Administration, dated 6/1/17, the P&P indicated, Medication will be administered by a Licensed Nurse per the order of an Attending Physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure:1. One of 41 sampled residents (Resident 86)'s medication was securely stored. This failure had the potential for medication to be accessed by unauthorized staff and residents.2. Medications were labeled for one of seven sampled residents (Resident 64) when Resident 64's insulin pen (a multi-use vial of medication to treat high blood sugar in the format of a pen which uses a needle for administration of the medication) was not labeled with Resident 64's identification. This failure had the potential for Resident 64 to use another resident's insulin pen or vice versa, placing Resident 64 and other residents at risk of the spread of blood/borne diseases (diseases spread through the blood). Findings: 1. During a concurrent observation and interview on 4/20/26 at 9:08 a.m. with Licensed Vocational Nurse (LVN) 3 in Resident 86's room, Resident 86 had methadone (controlled medication [high risk of abuse] used to treat opioid use disorder) 90 mg (milligram) found on the bedside table. There was a label on the bottle with Resident 86's name and methadone 90 mg dated 4/18/26 and had pink fluid in the bottle. LVN 3 stated methadone was given by the night shift nurse and the bottle still had 1 ml (milliliter) medication left. LVN 3 stated medication should not be left at bedside. During an interview on 4/21/26 at 3:09 p.m. with Resident 86, Resident 86 stated some nurses watch her take her medication and some of the nurses just leave the bottle with Resident 86 on the bedside table and she would take the medication unsupervised. Resident 86 stated on 4/20/26 a medication bottle was left on her bedside table, and she did not think she finished all the medication and just fell asleep. During a concurrent interview and record review on 4/22/26 at 10:04 a.m. with Director of Nursing (DON), Resident 86's Medical Record (MR), [undated] was reviewed. DON stated there was no care plan or self-administer assessment completed on Resident 86. DON stated Resident 86 could not store her medications at bedside and could not take medications unsupervised. During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, Controlled Substance Storage, dated 1/2022, the P&P indicated, B. Schedule [II-V] medications and other medications subject to abuse or diversion are stored in a permanently affixed, [double-locked] compartment separate from all other medications or per state regulations.H. Controlled substances are not surrendered to anyone, including the resident's physician, other than releasing controlled medications for a resident. During a review of the facility's P&P titled, Medication Storage in the Facility, Bedside medication storage, dated 1/2022, the P&P indicated, Bedside medication storage is permitted for residents who wish to self-administer medications, upon the written order of the prescriber and once the self-administration skills have been assessed and deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team. 2. During a concurrent observation and interview on 4/20/26 at 11:37 a.m. with LVN 4 in the hallway in front of nurses' station 1, LVN 4 stated she was going to administer insulin to Resident 64. LVN 4 retrieved an unlabeled insulin pen from the medication cart and stated it was Resident 64's insulin (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pen. The insulin pen had no resident identification. LVN 4 stated the label with Resident 64's identification had fallen off the insulin pen. During an interview with the DON on 4/27/26 at 1:25 p.m., DON stated insulin pens should be labeled with the resident's identification. During a review of facility P&P titled, Medication Ordering and Receiving From Pharmacy, dated 1/2022, the P&P indicated, Labels are permanently affixed to the outside of the prescription container.