

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555912	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER Kern River Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 5151 Knudsen Drive Bakersfield, CA 93308	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46958</p> <p>Based on interview and record review the facility failed to notify the physician of a change of condition for one of three sampled residents (Resident 1). This failure had the potential for Resident 1 not having his care needs met.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 7/23/24 at 2:50 p.m. with DON, Nursing-Daily Skilled Charting Form-V 3.0 (NDCF) , dated 5/25/2024 was reviewed. The NDCF indicated a blood pressure (BP - the pressure of circulating blood against the walls of blood vessels) of 184/82 (normal blood pressure is when systolic pressure of less than 120 and a diastolic pressure of less than 80). DON reviewed Resident 1's clinical records and stated there is no documentation that Resident 1 was re-assessed or if physician was notified for the high blood pressure. DON stated anything over 160 should be reported to physician.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated February 2021, the P&P indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status.5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's [NAME]/mental condition or status.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555912	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER Kern River Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 5151 Knudsen Drive Bakersfield, CA 93308	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>46958</p> <p>Based on interview and record review the facility failed to develop and implement a comprehensive person focused care plan for one of three sampled residents (Resident 1) when Resident 1 was non-compliant with the use of call light. This failure placed Resident 1 at risk for not having his care needs met.</p> <p>Findings:</p> <p>During a review of Nurse ' s Note (NN), dated 5/26/24, the NN indicated, Resident [1] noted to be non-compliant to call light. Use of call light explained to resident [1] within each interaction. Still non-compliant to call light and yelling at staff when needing assistance at this time.</p> <p>During a concurrent interview and record review on 7/9/24 at 10 a.m. with Assisted Director of Nursing (ADON), Resident 1 ' s Care Plan, dated 5/16/24-5/27/24 was reviewed. ADON reviewed Resident 1's Care Plan and stated there should ' ve been a care plan in place for a non-compliance with the use of call light.</p> <p>During an interview on 7/9/24 at 11:30 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 was very non-compliant with using his call light. Staff would always remind him to use call light, but Resident 1 sometimes would use call light and most of the time Resident 1 would just yell for help.</p> <p>During a review of Resident 1 ' s Brief Interview for Mental Status (BIMS,) dated 5/20/2024, the BIMS indicated, Resident has a score of 12 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment 13-15 cognitive is intact).</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 2022, the P&P indicated, A comprehensive, person-centered care plan for the resident should be developed by the interdisciplinary team (IDT), with input from the resident, and his/her family or legal representative.8. The interdisciplinary team should review and update the care plan: a. when there has been a significant change in the resident ' s condition.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555912	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER Kern River Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 5151 Knudsen Drive Bakersfield, CA 93308	

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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>46958</p> <p>Based on interview and record review, the facility failed to ensure the communication and coordination between the facility and dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working) center was complete with assessments of the dialysis access site (surgically created access) on the Pre (before) and Post (after) Dialysis Communication Form (PDCF) for one of two sampled residents (Resident 1). This failure had the potential to result in complications due to having no assessment of the dialysis site.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 7/23/24 at 2 p.m. with Director of Nursing (DON), Resident 1's Pre and Post-Dialysis Communication Form (PDCF) dated 5/17/24, 5/20/24 and 5/22/24 was reviewed. The PDCF indicated post -Dialysis Assessment was blank on 5/17/24, 5/20/24 and 5/22/24. DON stated the post dialysis was not completed and it (PDCF) should be completed once Resident 1 is back in the facility.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Hemodialysis Catheters-Access and Care of, dated February 2023, the P&P indicated, The nurse should document in the resident's medical record every shift as follows: 1. Location of catheter. 2. Condition of dressing (interventions of needed). 3. If dialysis was done during shift. 4. Any part of report from dialysis nurse post-dialysis being given. 5. Observation post-dialysis.</p>