

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  08/22/2024
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>39763</p> <p>Based on interview and record review, the facility failed to notify the attending physician (AP) and responsible party (RP) and complete a change of condition (COC) for one of three sampled residents (Resident 1) when Resident 1 had two unwitnessed falls and COCs. This failure had the potential for Resident 1's AP and RP to be unaware of Resident 1's change of condition and had the potential for unmet care needs and treatments.</p> <p>Findings:</p> <p>During an interview on 8/22/24 at 1:03 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the resident's AP and RP should be notified for any COC and complete a COC and document AP and RP notification.</p> <p>During a review of Resident 1's Nurse's Note, (NN) dated 7/15/24, the NN indicated, (Resident 1) found sitting on the floor between his wheelchair and toilet. (Resident 1) stated he attempted to put (sic) himself back to his wheelchair from the toilet. No obvious injuries noted. nurse notified MD and family.</p> <p>During a review of Resident 1's 72-hour Charting, (72HC) dated 7/22/24, the 72HC indicated, At 2:45 pm CNA called for nurse's help to (Resident 1's) room d/t (do to) (Resident 1) being on the floor. RN (registered nurse) was then called as well for initial assessment. (Resident 1) denies hitting his head (no MD or family notification documented).</p> <p>During a concurrent interview and record review on 8/22/24 at 1:47 p.m. with Director of Nursing (DON), Resident 1's NN, dated 7/15/24, and 72HC, dated 7/22/24 were reviewed. DON confirmed Resident 1 had two unwitnessed falls and there was no evidence the AP and RP were notified of Resident 1's fall on 7/22/24. Resident 1's medical record was reviewed. DON confirmed Resident 1 did not have a COC or SBAR (Situation, Background, Assessment, and Recommendation- communication tool) for the fall incidents on 7/15/24 and 7/22/24.</p> <p>(continued on next page)</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
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Change in a Resident ' s Condition or Status, revise February 2021, the P&amp;P indicated, Our facility promptly notifies the resident, his or her attending physician, the resident representative of change in the resident ' s medical/mental condition . 1. The nurse will notify the resident ' s attending physician or physician on call when there has been a (an): a. accident or incident involving the resident; . 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. 4. Unless otherwise instructed by the resident, a nurse will notify the resident ' s representative when: a. the resident is involved in any accident . 5. Except in medical emergencies, notifications, will be made within twenty-four (24) hours of a change occurring in the resident ' s medical/mental condition or status.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>39763</p> <p>Based on interview and record review, the facility failed to ensure the fall risk care plan was revised for one of three sampled residents (Resident 1). This failure had the potential for harm and injuries to Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Fall Risk Observation/Assessment, (FROA) dated 5/19/24, the FROA indicated Resident 1 scored an 18 (a score of 16-42 indicate high risk for falls).</p> <p>During a review of Resident 1 ' s Nurse's Note, (NN) dated 7/15/24, the NN indicated, (Resident 1) found sitting on the floor between his wheelchair and toilet.(Resident 1) stated he attempted toput (sic) himself back to his wheelchair from the toilet. No obvious injuries noted.</p> <p>During a review of Resident 1 ' s 72-hour Charting, (72HC) dated 7/22/24, the 72HC indicated, At 2:45 pm CNA called for nurse ' s help to (Resident 1 ' s) room d/t (do to) (Resident 1) being on the floor. RN (registered nurse) was then called as well for initial assessment. (Resident 1) denies hitting his head.</p> <p>During a concurrent interview and record review on 8/22/24 at 1:47 p.m. with Director of Nursing (DON), Resident 1 ' s NN, dated 7/15/24, and 72HC, dated 7/22/24, were reviewed. DON confirmed Resident 1 had two separate falls. Resident 1 ' s care plans were reviewed. DON confirmed Resident 1's fall risk care plan was not revised after the fall incident on 7/15/24 or the fall incident on 7/22/24. DON stated the CP should be revised after each fall.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Falls-Clinical Protocol, revised September 2012, the P&amp;P indicated, 5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc. 6. Falls should be categorized as: a. Those that occurred while trying to rise from a sitting position; b. Those that occur while upright and attempting to ambulate; and c. Other circumstances such as sliding out of a chair or rolling from a low bed to the floor. Treatment/Management 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and address risks of serious consequences of falling. 2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation .</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>39763</p> <p>Based on interview and record review, the facility failed to ensure neurological checks (assessment of sensory and motor responses, especially reflexes, to determine whether the nervous system is impaired) were initiated and completed for one of three sampled residents (Resident 1) after Resident 1 had two unwitnessed falls. This failure had the potential for sign and symptoms of neurological deficits to go unrecognized for Resident 1 which had the potential for adverse outcomes.</p> <p>Findings:</p> <p>During an interview on 8/22/24 at 1:03 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated if the fall was unwitnessed, he would initiate neurological checks. LVN 1 stated Neurological check lasted for 72 hours.</p> <p>During a review of Resident 1 ' s Nurse ' s Note, (NN) dated 7/15/24, the NN indicated, (Resident 1) found sitting on the floor between his wheelchair and toilet. (Resident 1) stated he attempted toput (sic) himself back to his wheelchair from the toilet. No obvious injuries noted .</p> <p>During a review of Resident 1 ' s 72-hour Charting, (72HC) dated 7/22/24, the 72HC indicated, At 2:45 pm CNA called for nurse ' s help to (Resident 1 ' s) room d/t (do to) (Resident 1) being on the floor. RN (registered nurse) was then called as well for initial assessment. (Resident 1) denies hitting his head.</p> <p>During a concurrent interview and record review on 8/22/24 at 1:47 p.m. with Director of Nursing (DON), Resident 1 ' s NN, dated 7/15/24, and 72HC, dated 7/22/24, were reviewed. DON confirmed Resident 1 had two separate unwitnessed falls. Resident 1 ' s medical record was reviewed. There were no neurological checks completed for the fall incident on 7/15/24 or the fall incident on 7/22/24, DON confirmed the findings.</p> <p>During a review of a facility provided form titled, Neurological Flow Sheet, undated, the form indicated, Vital signs and Neuro Checks: Q (every) 15 min (minutes) x (times) (1) hour Q 30 mins x (4) hours then, Q 4 hours x (72) hour . Please keep this sheet for 72 hours. If another fall occurs, please start a new sheet DO NOT continue same sheet. Notify MD IMMEDIATELY of s/s of intracranial pressure.</p>

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39763</p> <p>Based on interview and record review, the facility failed follow its own policy and procedure (P&amp;P) titled, Documentation Accuracy In The Health Record, for one of three sampled residents (Resident 1). This failure resulted in Resident 1 ' s medical record to be inaccurate.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 8/22/24 at 1:47 p.m. with Director of Nursing (DON), Resident 1 ' s Admission Record, (AR) was reviewed and indicated Resident 1 was admitted on [DATE]. DON confirmed Resident 1 ' s AR indicated Resident 1 ' s emergency contact (EC) was his wife. Resident 1 had no other responsible party or EC listed. Resident 1 ' s Discharge Summary, (DS) dated 8/1/24 was reviewed. DON confirmed the DS indicated, I have read, understand and received a copy of this discharge summary: IV. Resident/Responsible Party/Date: (Resident 2 ' s name) V. Relationship to resident/date self . DON confirmed Resident 2 was a resident in the facility and not in any way affiliated with Resident 1.</p> <p>During a review of the facility ' s P&amp;P titled, Documentation Accuracy In The Health Record, undated, the P&amp;P indicated, Clinical records should accurately reflect the care given by each member of the health care team as well as the response of the person receiving services. Accurate records are vital to the individual, to the staff and to the facility administrators. For a resident, the clinical record should ensure continuity of care; for staff, it assists in coordination of services and of serves as proof of work done; . The clinical record is also a legal document. Under the doctrine of Respondent Superior, the health care institution is responsible for the actions of its employees. In litigation, the accurate recording of the facts of the situation is the best defense, .</p>		