STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555912	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kern River Transitional Care	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 34401 Based on interview and record review, the facility failed to implement its own Fall Management policy and procedure (P&P) for one of six sampled residents (Resident 1). This failure resulted in an incomplete post fall assessment for Resident 1 and had the potential for unmet care needs. Findings: During an interview on 12/9/24 at 12:30 p.m. with Director of Nurses (DON), DON stated Resident 1 had a history of falling. DON stated Resident 1 had a fall incident on 11/28/24 in the bathroom and an unwitnessed fall incident on 12/2/24. DON stated Resident 1 was a high risk for falls. During a review of Resident 1' Post Fall Review (PFR) assessment dated [DATE], the assessment was noted to be incomplete. The PFR assessment did not indicate Resident 1's medications. During a concurrent interview on 12/9/24 at 1:30 p.m. with DON and Administrator, DON stated it was the facility policy to complete a PFR assessment after each fall. DON stated the PFR assessment included a review of the residents' medications, cognition, behavior, and incontinence to help determine the cause of the fall. DON and Administrator reviewed Resident 1's PFR assessment dated [DATE]. DON and Administrator confirmed the PFR assessment dated [DATE] was incomplete. DON stated Resident 1's medications was not assessed. During a review of the facility's P&P titled Fall Management, dated 10/24, the P&P indicated, Fall Event 1. When a fall occurs, the resident is assessed for injury by the nurse. 2. The will: . d. Initiate the Interdisciplinary Post Fall Review UDA. 5. The IDT will complete the Interdisciplinary Post Fall Review UDA.

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