

| | | | |
|--|--|--|--|
| 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 02/25/2025 |
| 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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>39763</p> <p>Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, for one of three sampled residents (Resident 1) when:</p> <ol style="list-style-type: none"> Care plan for refusal of care was not developed and implemented. This failure resulted in Resident 1 not receiving showers or baths for 13 days. Respiratory Care plan was not developed and implemented. This failure had the potential for Resident 1's respiratory signs and symptoms to go unnoticed. <p>Findings:</p> <ol style="list-style-type: none"> During a concurrent interview and record review on 2/25/25 at 3:01 p.m. with Director of Nursing (DON), Resident 1's Shower Sheets, dated 2/6/25, 2/10/25, 2/13/25, and 2/17/25 were reviewed. DON confirmed Resident 1 refused all showers and baths offered. Resident 1's care plans were reviewed. DON confirmed no care plan was developed or implemented for Resident 1's refusals for showers and baths. DON confirmed a refusal care plan should have been developed and implemented for Resident 1's refusals for showers and baths. During a review of Resident 1's Admission Record, (AR) dated 2/5/25, the AR indicated, Resident 1 had a diagnosis of asthma (chronic lung disease caused by inflammation and muscle tightening around the airways, which makes it harder to breathe), interstitial pulmonary disease (group of chronic lung conditions that cause inflammation and scarring of the lungs; scarring leads to stiff and thickened lungs, making it difficult for oxygen to enter the bloodstream), chronic obstructive pulmonary disease (group of lung diseases that cause airflow obstruction and breathing difficulties), respiratory disorders, and atelectasis (a condition where part or all of a lung collapses, leading to a reduction in oxygen exchange). <p>During a concurrent interview and record review on 2/25/25 at 3:01 p.m. with DON, Resident 1's AR was reviewed. DON confirmed Resident 1 had five diagnoses affecting the respiratory system. Resident 1's care plans were reviewed. DON confirmed no respiratory care plan was developed or implemented for Resident 1. DON stated a respiratory care plan should have been developed and implemented for Resident 1's respiratory care.</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 |
|---|-------|-----------|

| | | | |
|--|--|--|--|
| 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 02/25/2025 |
| 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 0656</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 P&P titled, Care Plans, Comprehensive Person-Centered, revised March 2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's needs is developed and implemented for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The comprehensive, person-centered care plan: . b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; . 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.</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 02/25/2025 |
| 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 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 obtain physician's order and document the removal of midline intravenous catheter (midline IV - a thin, flexible tube inserted into a vein in the upper arm; used to administer medications, fluids, or draw blood over a longer period) for one of three sampled residents (Resident 1). These failures had the potential for Resident 1 to have retained piece of the catheter, blood loss and incomplete medical record.</p> <p>Findings:</p> <p>During a review of Resident 1's Medication Administration Record, (MAR) for February 2025, the MAR indicated Resident 1 was administered Meropenem (used to treat infections caused by bacteria) intravenous . every 6 hours for C-Diff (Clostridium difficile - a bacteria that cause inflammation of the large intestine) for 6 Days -Start Date-02/5/2025 1800 (6 pm). The MAR indicated Resident 1's last dose of meropenem was administered on 2/11/25 at 12pm.</p> <p>During a review of Resident 1's Infection Note, (IN) dated 2/12/25, the IN indicated, (Resident 1) is no longer on strict single room isolation .</p> <p>During a review of Resident 1's Medication Administration Note, (MAN) dated 2/13/25, the MAN indicated, No IV line access .</p> <p>During a concurrent interview and record review, on 2/25/25 at 3:01 p.m. with Director of Nursing (DON), DON stated a physician must give orders to remove the midline IV catheter. DON stated once the midline IV is removed the nurse should measure the length of the catheter, ensure the tip was intact, assess resident bleeding, and document in a progress note. Resident 1's physician's orders were reviewed. DON confirmed Resident 1 had no order for midline IV removal. Resident 1's Progress Notes, were reviewed. DON stated there was no documentation of the removal of midline IV in the progress notes. DON stated the removal of the midline IV should have been documented.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Guidelines for Preventing Intravenous Catheter-Related Infections, revised August 2014, the P&P indicated, Replacement of IV Catheters 1. Promptly obtain physician order for the removal of any peripheral or central IV catheter that is no longer essential. 9. Removal of a midline or any central line is to be performed upon the order of a Physician or authorized prescriber in accordance with State Nurse Practice Act. Documentation The following information should be recorded in the resident's medical record: . 2. Any interventions that were done . 4. Communication with Physician, Supervisor, oncoming shift.</p> | | |