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	05/16/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34510 Based on observation, interview, and record review, the facility failed to: 1. Ensure one of three sampled residents (Resident 1) was wearing non-skid socks (non-slip socks are designed with rubberized grips on the soles, offering the traction needed to walk safely. This feature is particularly vital for elderly residents or those with balance problems, significantly reducing the risk of falls and related injuries) according to the plan of care when Resident 1 was high risk for falls. 2. Follow their in-service on Falls to ensure a Registered Nurse (RN) initially assessed one of three residents (Resident 1) who was found on the floor when a Licensed Vocational Nurse (LVN) 1 did not wait for the RN to assess before transferring Resident 1 from the floor to the wheelchair and to the bed. These failures had the potential to result in Resident 1 falling and sustaining a left hip fracture (broken bone). Findings: 1. During a review of Resident 1's Change in Condition Evaluation (CCE), dated 3/29/25, the CCE indicated, Resident [1] had an unwitnessed fall in her room attempting to the restroom [sic] without assistance. Pain level was assessed. Resident c/o [complained of] pain on her left hip. Resident [1] was then helped into her wheelchair and subsequently into her bed. During a review of Resident 1's Fall Risk Observation/Assessment (FROA), dated 3/12/25, the FROA indicated, Score: 26 [score of 16-42 means high risk for falls]. During a review of Resident 1's Care Plan (CP), dated 3/13/25, the CP indicated, [Resident 1] is at risk for falls. Interventions: Provide proper well-maintained footwear as indicated (Non-Skid Socks, etc). During an interview on 5/16/25 at 9:08 a.m. with CNA 1, CNA 1 stated Resident 1 was not wearing non-skid socks when she fell . CNA 1 stated she removed Resident 1 ' s non-skid socks when she placed Resident 1 in bed prior to the fall incident. (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
	555912	A. Building B. Wing	05/16/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/25 at 9:32 a.m. with Director of Staff Development (DSD), DSD stated Resident 1 should be wearing non-skid socks at all times. During an interview on 5/17/25 at 10:22 a.m. with LVN 1, LVN 1 stated when he went to assess Resident 1 after the fall incident, Resident 1 was not wearing non-skid socks. During a review of the facility's policy and procedure (P&P) titled, Falls-Clinical Protocol dated March 2018, the P&P indicated, Based on preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent fals and to address the risks of clinically significant consequences of falling. 2. During an interview on 5/16/25 at 9:08 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated LVN 1 called her when LVN 1 found Resident 1 on the floor by the door of the bathroom. CNA 1 stated Resident 1 complained of left hip pain. CNA 1 stated she asked LVN 1 to help her lift Resident 1 back to bed. CNA 1 stated LVN 1 lifted Resident 1 by her upper body and CNA 1 lifted Resident 1's legs to the wheelchair then to Resident 1 ' s bed. CNA 1 stated Resident 1 continued to complain of pain. During a concurrent observation and interview on 5/16/25 at 9:30 a.m. in Resident 1's room, with Resident 1, Resident 1 was in bed with a bed alarm attached to the bed. Resident 1 stated she remembered she had a pain in her left hip when she fell . During an interview on 5/16/25 at 10:35 a.m. with RN Supervisor (RNS), RNS stated he was called to assess Resident 1 after the fall incident. RNS stated he went to see Resident 1 in less than five minutes. RNS stated, When I got there [Resident 1 ' s room], she [Resident 1] was already in bed. Resident [1] was holding her left hip complaining of pain. RNS stated he suspected hip fracture right away, so he sent Resident 1 to the acute care hospital. RNS stated LVN 1 did not wait for him to assess Resident 1 before transferring Resident 1 to the bed. During an interview on 5/17/25 at 10:22 a.m. with LVN 1, LVN 1 stated he was aware RNS should initially assess Resident 1 prior to transferring Resident 1 after the fall incident. LVN 1 stated he did not wait for RNS prior to moving/transferring Resident 1. During a review of the facility's in-service on Falls dated 3/4/25, the in-service on Falls indicated, If a fall occurs: Supervisor [RN] to assess resident prior to moving or touching the resident. Residents must be assessed prior to lifting or transferring resident to ensure it is safe to do so. RN supervisor will delegate if the resident should be referred to 911 services.