

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 05/16/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>39650</p> <p>Based on observation, interview, and record review, the facility failed to maintain dignity for two of 57 sampled Residents (Resident 389 and Resident 84) when:</p> <ol style="list-style-type: none"> 1. Resident 389 was dressed in donated clothing due to a delay in washing her personal clothing. 2. Resident 84's oral hygiene was not maintained. <p>These failures had the potential to negatively affect Resident 389 and Resident 84's psychosocial wellbeing and Resident 84's dental health.</p> <p>Findings:</p> <p>1. During a concurrent observation and interview on 5/13/24 at 11:45 a.m. with Resident 389's family member (FM) 1 in Resident 389's room, Resident 389 was in bed wearing a white undershirt with a plaid button up shirt and blue jeans. Resident 389 stated she did not have her own clothes to wear. One item of clothing was in her drawer and 2 jackets in her closet. Resident 389 stated she did not like the way the clothes she was wearing felt and did not like to wear someone else's clothes. Resident 389 stated the clothes were too big and not comfortable. Resident 389 demonstrated how big the jean pants were around her waist. Resident 389 stated she liked to wear jeans but not jeans that big and not when she laid in bed. FM 1 stated Resident 389 was wearing someone else's clothes because the laundry had not been done and she did not have her own clothes to wear. FM 1 stated Resident 389's personal clothes were picked up by staff and taken to the facility laundry last week and had not been returned. FM 1 stated he called the facility on Saturday to check on Resident 389's personal laundry and it was still not clean.</p> <p>During a concurrent observation and interview on 5/15/24 at 9:30 a.m. with Resident 389, Resident 389 was sitting in bed. Resident 389 stated the clothes she had on were her own. Resident 389 stated she was finally in her own clothes and it made her feel so much better.</p> <p>During an interview on 5/15/24 at 10:48 a.m. with Environmental Services Manager (EVS) 1, EVS 1 stated once laundry staff pick up resident's personal laundry bags with soiled clothes, the clothes should be washed and returned to the resident in two to two and one half days. EVS 1 stated the residents who bring their personal clothes should have their own clothes clean and ready to wear.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/15/24 at 11:07 a.m. with Laundry Staff (LS), LS stated she came in to work on 5/13/24 and she was told the family of Resident 389 wanted Resident 389's clean personal clothes returned from the laundry. LS stated she was not sure why Resident 389's personal clothes were not laundered sooner. LS stated she returned Resident 389's personal clothes to her room in the afternoon on 5/13/24. LS stated Resident 389 told her she was happy to be able to wear her own clothes again. LS stated laundry services should keep track, pick up, and process the laundry, so the residents' do not run out of their own clothes.</p> <p>During an interview on 5/15/24 at 11:16 a.m. with EVS 1, EVS 1 stated laundry services had problems with turnaround time of residents' laundry.</p> <p>During an interview on 5/15/24 at 2:52 p.m. with Certified Nursing Assistant (CNA) 3. CNA 3 stated on 5/13/24, she obtained donated clothes from the laundry room to dress Resident 389 after her morning shower because she did not have any clean personal clothes. CNA 3 stated there were only pajamas in her drawer on 5/13/24. CNA 3 stated when she assisted Resident 389 up to the bathroom, after she was dressed, Resident 389's pants were sliding down because they were too big.</p> <p>During an interview on 5/16/24 at 8:33 a.m. with Administrator, Administrator stated the expectation was for laundry to be done regularly and timely, to ensure residents have their personal clothes available to wear.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Laundry Charges/Pick Up, (undated), the P&P indicated, Residents will be provided with personal laundry service at no cost.</p> <p>42744</p> <p>2. During a review of Resident 84's Admission Record (AR), the AR indicated Resident 84 had a diagnosis of Amyotrophic Lateral Sclerosis (ALS - a nervous system disease causing a loss of muscle control).</p> <p>During a review of Resident 84's Minimum Data Set (MDS- resident assessment tool), dated 4/18/24, the MDS indicated Resident 84 was dependent (total assistance) for oral hygiene.</p> <p>During a review of Resident 84's Medication Administration Record (MAR), dated May 2024, the MAR indicated, Oral care Q (every) Shift and Oral suctioning for excess secretions with a suction toothbrush for inability to swallow. two times a day for Removal of excess secretions.</p> <p>During a concurrent observation and interview on 5/14/24 at 2:55 p.m. with Resident 84 and FM 2 in Resident 84's room, Resident 84 was sitting up in a wheelchair with a computer attached to it, approximately 12 inches from Resident 84's face at eye level. Resident 84 used this device to communicate using eye movements. Resident 84 had a full mouth of teeth with yellowish white debris along the gum line of the bottom teeth. The lower teeth were coated with a film. FM 2 stated oral care was lacking for Resident 84. FM 2 stated Resident 84 had a toothbrush attached to her suction machine. FM 2 stated using the toothbrush for a minute or two would work well. Resident 84 moved her head slightly indicating No when asked if her teeth had been brushed that morning or the day before. Resident 84 typed out on the computer, Nurse is supposed to do oral care with suction but has no time for it.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/16/24 at 11:38 a.m. with Resident 84, Resident 84 typed out on her computer, I know they are busy but I feel like I don't matter.</p> <p>During an interview on 5/16/24 at 11:53 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated failure to provided oral care for Resident 84 was a dignity issue.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Dignity, dated 2001, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.</p>

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47153</p> <p>Based on observation, interview, and record review, the facility failed to ensure a physician order (PO) was obtained and Self-Administration of Medication Assessment ([NAME]) was completed for one of one sampled resident (Resident 40). This failure had the potential for unsafe and inappropriate self-administration of medication.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 5/13/24 at 10:32 a.m. with Resident 40, in Resident 40's room, one bottle multivitamins was found on Resident 40's bedside table. Resident 40 stated he takes the multivitamins on the bedside table two times daily.</p> <p>During a concurrent interview and record review on 5/13/24 at 10:42 a.m. with Assistant Director of Nursing (ADON), Resident 40's POs and assessments were reviewed. ADON was unable to provide PO or [NAME] for the use of the multivitamin found on Resident 40's bedside table. ADON stated Resident 40 should have had a PO and a [NAME] to ensure Resident 40 was safe to self-administer the medications.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Self-Administration of Medications, dated February 2021, the P&P indicated, Residents have the right to self-administer medications if the interdisciplinary team [IDT- team of multiple disciplines working together] has determined that it is clinically appropriate and safe for the resident to do so .1. As part of the evaluation comprehensive assessment, the interdisciplinary team assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.</p>		

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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>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 ensure one of 57 sampled residents (Resident 134) was notified of a room change. This failure had the potential for Resident 134, Resident 134's family and Medical Doctor (MD) not to be informed of reason for room change.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 5/13/24 at 4:19 p.m. with Director of Nursing (DON), DON reviewed Resident 134's medical record and confirmed Resident 134's room was changed on 4/22/24. DON reviewed Resident 134's Notice of Room Change, (NRC) dated 4/22/24. DON confirmed the NRC was blank (no indication for the room changes, no notification to family, or MD).</p> <p>During a review of the facility's policy and procedure (P&P) titled, Room Change/Roommate Assignment, revised May 2017, the P&P indicated, 2. Unless medically necessary or for the safety and well-being of the resident (s), a resident will be provided with an advance notice of the room change. Such notice will include the reason(s) why the move is recommended.6. Documentation of a room change is recorded in the resident's medical record.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>47444</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of 57 sampled residents (Resident 41), was provided a homelike environment. This failure had the potential to negatively effect Resident 41's mental wellbeing.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 5/14/24 at 11:10 a.m. with Resident 41, in Resident 41's room, Resident 41 in his wheelchair with legs extended straight out in front of him. The corner where two walls met, next to Resident 41's bed, was damaged. The damaged area was approximately four feet high and four feet wide, with scraped, chipped, and missing patches of drywall, exposed metal edges, mesh material and holes. Resident 41 stated he ran into the wall with his wheelchair almost everyday and it had not been repaired since he lived there. Resident 41 stated he would like the wall damage to be repaired because it was his home.</p> <p>During a review of Resident 41's electronic medical record (EMR), the EMR indicated Resident 41 had lived in the room since 10/18/23.</p> <p>During an interview on 5/15/24 at 9:18 a.m. with Housekeeper (HK) 1, HK 1 stated she had not reported the damaged wall in Resident 41's room to maintenance.</p> <p>During a concurrent interview and record review on 5/15/24 at 2:42 p.m. with Licensed Vocational Nurse (LVN) 2, the Maintenance Work Order Log (MWOL), dated January 2024 through May 2024, was reviewed. The MWOL indicated Resident 41's wall damage was not recorded on the log. LVN 2 stated the damage should have been recorded in the log because wall damage can place Resident 41 at risk for developing an infection and it is also his home.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated February 2021, the P&P indicated, Policy Statement Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.</p> <p>During a review of the facility's P&P titled, Maintenance Service, dated December 2009, the P&P indicated, Policy Interpretation and Implementation 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: . b. Maintaining the building in good repair and free from hazards.</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>42744</p> <p>Based on interview and record review, the facility failed to update the Quarterly Minimum Data Set (MDS-resident assessment tool) Comprehensive Assessment (QMDSCA) for one of one sampled resident (Resident 48) with a new mental disorder diagnosis. This failure had the potential to inaccurately reflect Resident 48's clinical status and result in an inaccurate plan of care.</p> <p>Findings:</p> <p>During a review of Resident 48's Nursing Home Visit (NHV), dated 2/12/24, the NHV indicated, Chief Complaint. Patient is seen for psychiatric evaluation at the request of primary care physician to assess the patient's behaviors and review of any psychotropic medications [medications that affect mind, emotions, and behavior]. Assessment. Post-traumatic stress disorder [PTSD-mental health condition triggered by a traumatic event]. Diagnosis attached to this encounter . Post-traumatic stress disorder.</p> <p>During a concurrent interview and record review on 5/15/24 at 2:11 p.m. with Minimum Data Set Nurse Assistant (MDSNA), Resident 48's Psychotropic IDT [PIDT - Interdisciplinary Team-multiple health care providers working together], dated 12/5/23 was reviewed. The PIDT indicated Resident 48 had PTSD with conversion disorder (a condition in which a person experiences physical and sensory problems) with anxiety, depression, and difficulty sleeping. MDSNA stated she was not aware Resident 48 had this diagnosis and she did not see it on Resident 48's diagnoses list.</p> <p>During a concurrent interview and record review on 5/15/24 at 2:13 p.m. with MDSNA, Resident 48's QMDSCA, Section I- Active Diagnosis, dated 2/17/24 was reviewed. Resident 48's QMDSCA indicated, Psychiatric/Mood Disorder .Traumatic Stress Disorder (PTSD) was not checked. MDSNA stated a diagnosis of PTSD would have automatically checked the PTSD question on MDS-Section I and it had not. MDSNA stated the new diagnosis of PTSD was not on the QMDSCA.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Certifying Accuracy of the Resident Assessment, dated 2001, the P&P indicated, Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47153</p> <p>Based on interview and record review, the facility failed to ensure two of three sampled residents (Resident 36 and Resident 48) had a new Level I Preadmission and Resident Review (PASRR-screening tool used to determine specialized mental health services). This failure resulted in Resident 36 and Resident 48 not receiving recommendations for specialized services to best meet their needs.</p> <p>Findings:</p> <p>During a review of Resident 36's Admission Record (AR), dated 5/14/24, the AR indicated, Resident 36 was admitted on [DATE]. A diagnosis of Schizoaffective Disorder, Bipolar Type [mental disorder affecting a person's ability to behave and think clearly] was added 6/15/22.</p> <p>During a concurrent interview and record review on 5/15/24 at 9:06 a.m. with Director of Nursing (DON), Resident 36's PASRR Level I Screening, dated 4/19/22 was reviewed. The PASRR Level I Screening indicated, Resident 36 did not have a diagnosis of mental illness. DON stated Resident 36 did have a mental illness, but facility was not aware at the time Resident 36 was admitted . DON stated facility did not submit a new Level I PASRR when the diagnosis of schizoaffective was added less than 30 days after Resident 36's admission. DON stated Resident 36 should have had a new Level I submitted to include the diagnosis of schizoaffective disorder.</p> <p>42744</p> <p>During a review of Resident 48's Nursing Home Visit (NHV), dated 2/12/24, the NHV indicated, Chief Complaint. Patient is seen for psychiatric evaluation at the request of primary care physician to assess the patient's behaviors and review of any psychotropic medications [medications that affect mind, emotions, and behavior]. Assessment. Post-traumatic stress disorder (PTSD- a mental health condition triggered by a traumatic event) . Diagnosis attached to this encounter . Post-traumatic stress disorder.</p> <p>During a concurrent interview and record review on 5/15/24 at 9:19 a.m. with DON, Resident 48's Preadmission Screening and Resident Review [PASRR] Level I Screening, dated 8/16/23 was reviewed. DON stated this was Resident 48's most recent PASRR Level I screening after she was readmitted from the hospital.</p> <p>During an interview on 5/15/24 at 9:34 a.m. with DON, DON stated the facility should have completed a review and submitted a new PASRR Level I screening when Resident 48's new PTSD diagnosis was added.</p> <p>During a review of the Department of Health Care Services (DHCS) website, the website indicated, PASRR Level I Screening Process . If a resident has experienced a significant change of condition, the NF (nursing facility) must initiate the RR (Resident Review) process by submitting a Level I Screening, regardless of the date of the last PASRR, and note in the resident's medical record that a significant change of condition has occurred.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>42744</p> <p>The facility failed to submit a Pre-Admission Screening and Resident Review (PASRR-screening tool used to determine specialized mental health services) Level I screening prior to admission for one of one sampled resident (Resident 48). This failure had the potential for Resident 48 to not receive mental health services.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 5/15/24 at 9:19 a.m. with Director of Nursing (DON), Resident 48's Preadmission Screening and Resident Review [PASRR] Level I Screening, dated 8/16/23 was reviewed. DON stated this was Resident 48's most recent screening after she was readmitted from the hospital.</p> <p>During an interview on 5/15/24 at 11:28 a.m. with DON, DON stated Resident 48 should have had two Level I PASRR screenings, one on admission 6/2/23 and another one on 8/16/23 when she was readmitted from the hospital. DON stated the PASRR on admission 6/2/23 was not done and should have been.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Admission Criteria-PASRR, dated March 2019, the P&P indicated, 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payor source, to determine if the individual meets the criteria for a MD, ID, or RD.</p>

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<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>42744</p> <p>Based on interview and record review, the facility failed to update the comprehensive care plan for one of one sample resident (Resident 48) when a new mental health condition was diagnosed . This failure had the potential to negatively impact care.</p> <p>Findings:</p> <p>During a review of Resident 48's, Nursing Home Visit (NHV), dated 2/12/24, the NHV indicated, Chief Complaint. Patient is seen for psychiatric evaluation at the request of primary care physician to assess the patient's behaviors and review of any psychotropic medications [medications that affect mind, emotions, and behavior]. Assessment. Post-traumatic stress disorder (PTSD- a mental health condition triggered by a traumatic event) . Diagnosis attached to this encounter .Post-traumatic stress disorder.</p> <p>During a concurrent interview and record review on 5/15/24 at 9:48 a.m. with Director of Nursing (DON), Resident 48's care plans were reviewed. The facility was unable to provide a care plan for the mental health diagnosis of PTSD. The DON stated resident should have had a care plan for PTSD.</p> <p>During a concurrent interview and record review on 5/15/24 at 2:27 p.m. with Social Services Director (SSD), Resident 48's Psychotropic IDT [PIDT- Interdisciplinary Team-multiple health care providers working together], dated 12/5/23 was reviewed. The PIDT indicated Resident 48 had PTSD with conversion disorder (a condition in which a person experiences physical and sensory problems). SSD stated for a resident with a new diagnosis, she should have done 72-hour psychosocial monitoring, requested a psychiatric consultation, and updated the care plan. SSD stated she did not remember doing this for Resident 48.</p> <p>Policy and procedure requested but not provided.</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:</p> <ol style="list-style-type: none"> Staff followed the facility's policy and procedure (P&P) titled, Medication Administration for one of one sampled resident (Resident 134) when the first dose of Lorazepam (medication used to treat anxiety) was not administered until 21 hours after the physician order (PO). This failure had the potential for Resident 134 to suffer unnecessary agitation. Staff followed the facility's P&P, titled Enteral [external] Tube Medication Administration for one of two sampled residents (Resident 18) with a Gastrostomy tube (G-tube, tube inserted directly into the stomach for nutrition and medication). This failure had the potential to place Resident 18 at risk for not receiving physician ordered medication or nutrition. <p>Findings:</p> <ol style="list-style-type: none"> During a review of Resident 134's Medication Administration Record, dated March 2024, the MAR indicated: Lorazepam Concentrate 2MG [milligrams- unit of measure]/ML [milliliter- unit of measure] give 0.25 ml sublingually [under the tongue] two times a day for Agitation -Start Date- 04/28/2024 2100 [9 p.m.] -D/C Date- 04/29/2024 1751 [5:51p.m.] <p>During a concurrent interview and record review on 5/13/24 at 4:19 p.m. with Director of Nursing (DON), DON reviewed Resident 134's MAR dated 4/2024. DON confirmed lorazepam was order 4/28/24 to start at 9 p.m. DON confirmed Resident 134 was not administered first does of lorazepam until 4/29/24 at 6 p.m. [21 hours after the medication was ordered].</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 2019, the P&P indicated, Medications are administered as prescribed in accordance with good nursing practices. Administration . B. Medications are administered in accordance with written orders of the attending physician. J. Medications are administered within (60 minutes) before or after the scheduled time, .</p> <p>50409</p> <p>During an observation on 5/14/24 at 2:33 p.m. in Resident 18's room, Licensed Vocational Nurse (LVN) 1, LVN 1 connected the syringe to Resident 18's G-tube. LVN 1 did not unclamp the G-tube. LVN 1 unsuccessfully attempted to withdraw residual (fluid drained from the stomach) fluid from Resident 18 stomach. LVN 1 unclamped the G-tube. LVN 1 added water to the syringe and a clear liquid with white debris came up the G-tube into the syringe. LVN 1 added Ferrous Sulfate Solution (liquid iron supplement) into the syringe. LVN 1 used the syringe plunger to push the water and liquid iron supplement mixture into the G-tube. The water and liquid iron supplement leaked out of the tubing.</p> <p>During an interview on 5/14/24 at 2:54 p.m. with LVN 1, LVN 1 stated he was supposed to unclamp the G-tube before checking for placement. LVN 1 stated he was not sure if he could use the plunger to push the medication into the G-tube.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Kern River Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 5151 Knudsen Drive Bakersfield, CA 93308	
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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>During a review of Resident 18's Order Details (OD), dated 5/2/24, the OD indicated, Ferrous Sulfate Oral Solution 220 (44 Fe) MG [milligram]/5ML [milliliter] (Ferrous Sulfate) Give 5 ml via PEG [Percutaneous Endoscopic Gastrostomy, Peg-tube, G-Tube]-Tube three times a day for Supplement.</p> <p>During a review of Resident 18's Order Listing Report (OLR), dated 5/15/24, the OLR indicated, Check Peg-tube for placement and patency [state of being open] prior to administering medications.</p> <p>During a review of Resident 18's Order Listing Report (OLR), dated 5/15/24, the OLR indicated, Check Peg-tube residual. If more than 100 mL residual obtained, turn off feeding and call MD [Medical Doctor]. Re-instill [put back] any gastric [stomach] content obtained back into the tube.</p> <p>During a review of the facility's P&P titled, Enteral Tube Medication Administration, dated 2019, the P&P indicated, Verify tube placement. A. Unclamp tube and use either of the following procedure: a. Insert a small amount of air into the tube with the syringe and listen to stomach with stethoscope or gurgling sounds; or b. Aspirate [withdraw] stomach contents with syringe. Allow medication to flow down tube via gravity. C. Give gentle boosts with the plunger (approximately 1 inch down) if the medication will not flow by gravity. Repeat if necessary. Do not push medications through the tube.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47153</p> <p>Based on observation, interview, and record review, the facility failed to carry out fall prevention interventions identified in the care plan for a resident at high risk for falls when the bed was left in a high position on two occasions for one of one sampled resident (Resident 78). This failure had the potential for Resident 78 to fall and become injured.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 5/13/24 at 10:13 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 78's room, Resident 78 was in bed with bed in a high position. CNA 1 stated the bed should have been down low because Resident 78 is at risk for falls.</p> <p>During a concurrent observation and interview on 5/14/24 at 9:07 a.m. with CNA 1 in Resident 78's room, Resident 78 was in bed with bed in a high position. CNA 1 stated the bed should not have been left that high.</p> <p>During a concurrent interview and record review on 5/16/24 at 8:08 a.m. with Director of Nursing (DON), Resident 78's Fall Risk Observation/Assessment (FROA), dated 4/10/24 and Care Plan (CP), dated 7/18/23 were reviewed. The FROA indicated, Score: 18. LOW RISK 0-8. MODERATE RISK 9-15. HIGH RISK 16-42. The CP indicated, Bed in low position. DON stated Resident 78 was high risk for falls and the bed should have been kept in low position.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, dated March 2018, the P&P indicated, Based on previous evaluations and current data, staff may identify interventions related to the resident's specific risks and causes in the attempt to reduce falls and minimize complications from falling. Resident centered fall prevention plans should be reviewed and revised. If interventions have been successful in preventing falls, such interventions should be continued.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>47153</p> <p>Based on observation, interview, and record review, the facility failed to provide care for an indwelling catheter (tube placed into the bladder to drain urine) to prevent infections and other complications for one of 13 sampled residents (Resident 25). This failure had the potential to result in infections and injury to the penis or bladder.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 5/13/24 at 12:15 p.m. with Certified Nursing Assistant (CNA) 2 in the B wing dining room, Resident 25 was sitting in a wheelchair with the indwelling catheter bag (urine collection bag) and tubing touching the floor under the wheelchair. CNA 2 stated it should not have been on the floor because it could have gotten pulled out or caused an infection. CNA 2 pushed Resident 25 to his room with the catheter bag dragging under the wheelchair.</p> <p>During an interview on 5/13/24 at 12:28 p.m. with Director of Nursing (DON), DON stated the urinary drainage bag should have been kept off the floor.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, dated August 2022, the P&P indicated, Be sure the catheter tubing and drainage bag are kept off the floor.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50409</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure the medication carts and medication room were free from expired medications. This failure had the potential for residents to receive expired medications and have adverse health outcomes. 2. Follow their policy and procedure (P&P) on medication labeling. This failure had the potential to result in medication errors. 3. Ensure an insulin (medication used to manage blood sugar levels) was dated. This failure had the potential for residents to receive insulin with decreased potency (strength of medication required to produce an effect). <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview on 5/15/24 at 10:03 a.m. with Director of Nursing (DON), in the medication room C, there was a box of emergency drug supply. The form on the box titled, Refrigerated Emergency Drug Supply had a kit expiration date of 1/31/24. DON verified the refrigerated emergency drug supply was expired and stated the expired refrigerated emergency drug supply box should not be in the refrigerator. During a concurrent observation and interview on 5/15/24 at 2:22 p.m. with Licensed Vocational Nurse (LVN) 2, in the hallway, there was an insulin labeled with Discard Date of 5/14/24 in the medication cart B south. LVN 2 stated the insulin was expired. <p>During a review of the facility's P&P titled, Medication Storage, dated 2019, the P&P indicated, Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal.</p> <ol style="list-style-type: none"> 2. During a concurrent observation and interview on 5/15/24 at 2:03 p.m. in the hallway, with LVN 3, there was a medication bottle labeled, [Resident 52] B8-2, containing 2 pills in the medication cart B north. The medication bottle was not labeled with medication name, specific directions for use, strength of medication, prescriber's name, date filled, and quantity of medication filled. LVN 3 stated she does not know what kind of medications were in the bottle. <p>During a concurrent observation and interview on 5/15/24 at 2:03 p.m. with LVN 3 in the hallway, the following medications in the medication cart B north were not labeled with residents' names:</p> <ol style="list-style-type: none"> a. Fluticasone Propionate and Salmeterol (medication used to treat difficulty breathing) b. ProAir Digihaler (medication used to treat difficulty breathing) <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>LVN 3 stated the medications were not labeled with residents' names.</p> <p>During a concurrent observation and interview on 5/15/24 at 2:22 p.m. with LVN 2 in the hallway, the following medications in the medication cart B south were not labeled with residents' names:</p> <p>a. Artificial Tears (eye drop medication used to relieve dry, irritated eyes)</p> <p>b. Fluticasone Propionate (medication used to treat difficulty breathing)</p> <p>LVN 2 verified the medications were not labeled with residents' names.</p> <p>During a review of the facility's P&P titled, Medication Labels, dated 2019, the P&P indicated, Each prescription medication label includes: A. Resident's name B. Specific directions for use, including route of administration. C. Medication Name D. Strength of medication E. Prescriber's name F. Date dispensed G. Quantity of medication dispensed.</p> <p>3. During a concurrent observation and interview on 5/15/24 at 2:05 p.m. with LVN 3, in the hallway, an insulin in the medication cart B north did not have an open date. LVN 3 stated she does not know when it was placed in the medication cart.</p> <p>During a review of the facility's P&P titled, Medication Storage, dated 2019, the P&P indicated, Insulin bottles/Pens are to be dated when opened and discarded as per manufacture recommendations.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47153</p> <p>Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&P) titled, Food For Residents From Outside Sources for one of one sampled resident (Resident 40) when Resident 40's coffee creamer was not dated when opened or stored in the refrigerator. This failure had the potential to cause foodborne illness.</p> <p>Findings:</p> <p>During an observation on 5/13/24 at 10:32 a.m. in Resident 40's room, there was a half empty bottle of coffee creamer on Resident 40's bedside table with no open date.</p> <p>During a concurrent observation and interview on 5/14/24 at 9:07 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 40's room, the half empty bottle of coffee creamer with no date was still on the bedside table. CNA 1 stated Resident 40 did not like to let them take it. CNA 1 stated the label on the bottle of coffee creamer indicated it should be refrigerated and discarded after 14 days. CNA 1 stated the bottle does not have an open date so there was no way to tell how long it had been there.</p> <p>During a concurrent interview and record review on 5/16/24 at 8:28 a.m. with Director of Nursing (DON), Resident 40's care plans (CP) were reviewed. DON stated if Resident 40 had a bottle of coffee creamer at bedside it should have been dated and stored in the refrigerator for safety. DON was unable to provide documented evidence of a care plan addressing Resident 40's refusal to allow staff to take or date food brought in from outside sources.</p> <p>During a review of the facility's P&P titled, Food For Residents From Outside Sources, dated 2018, the P&P indicated, Food brought in from outside the facility kitchen for resident's consumption will be monitored. perishable food that requires refrigeration, can be stored for the resident in the facility kitchen, nursing station's refrigerator, or in the residents' personal refrigerator. If opened, the food must be sealed, dated to the date opened and disposed of in 2 days after opening. Food or beverages should be labeled and dated to monitor for food safety.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42744</p> <p>Based on interview and record review, the facility failed to maintain an accurate medical record (MR) for one of 57 sampled residents (Resident 48) when:</p> <ol style="list-style-type: none"> 1. A mental health diagnosis of Post Traumatic Stress Disorder (PTSD- a mental health condition triggered by a traumatic event) was not added to Resident 48's diagnoses list. 2. A mental health diagnosis of psychosis (symptoms include confused thinking, false beliefs, and hallucinations [hearing, seeing, smelling, or tasting something that is not there]) was dropped from Resident 48's diagnoses list. <p>These failures resulted in an incomplete and inaccurate medical record and had the potential to impact patient care.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent interview and record review on 5/15/24 at 9:37 a.m. with Director of Nursing (DON), Resident 48's active diagnoses were reviewed. The active diagnoses indicated no diagnosis for PTSD. DON stated PTSD was not on the diagnosis list and should have been added. <p>During a concurrent interview and record review on 5/15/24 at 2:11 p.m. with Minimum Data Set (MDS- resident assessment tool) Nurse Assistant (MDSNA), Resident 48's Psychotropic IDT (PIDT - Interdisciplinary Team - team of health care providers working together), dated 12/5/23 was reviewed. The PIDT indicated Resident 48 had PTSD with conversion disorder (a condition in which a person experiences physical and sensory problems) with anxiety, depression, and difficulty sleeping. MDSNA stated she was not aware Resident 48 had this diagnosis and she did not see it on the diagnoses list.</p> <p>During a concurrent interview and record review on 5/15/24 at 2:13 p.m. with MDSNA, Resident 48's MDS's, Section I- Active Diagnosis, dated 1/2/24 and 1/10/24, were reviewed. Resident 48's MDS's indicated Psychiatric/Mood Disorder . 16100. Post Traumatic Stress Disorder (PTSD) were not checked. MDSNA stated an ICD-10 coded diagnosis of PTSD would have automatically checked the PTSD question on MDS- Section I and it had not.</p> <p>During a concurrent interview and record review on 5/15/24 at 2:27 p.m. with Social Services Director (SSD), Resident 48's PIDT, dated 12/5/23 was reviewed. The PIDT indicated Resident 48 had PTSD with conversion disorder. DSD stated she does not remember how Resident 48 got this diagnosis and stated, I don't remember it being PTSD before.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 5/16/24 at 10:43 a.m. with Medical Record Clerk (MRC), Resident 48's Nursing Home Visit (NHV), dated 2/12/24, was reviewed. The NHV indicated, Chief Complaint. Patient is seen for psychiatric evaluation as the request of primary care physician to assess the patient's behaviors and review of any psychotropic medications. Assessment. Post-traumatic stress disorder. Diagnosis attached to this encounter . (F43.10) Post-traumatic stress disorder. MRC stated the PTSD diagnosis should be in the chart and is not. MRC stated it makes the MR incomplete and inaccurate.</p> <p>2. During a concurrent interview and record review on 5/15/24 at 2:14 p.m. with MDS Director (MDS), Resident 48's MDS's, Section I- Active Diagnosis, dated 1/2/24 and 1/10/24 were reviewed. MDS dated [DATE] indicated Resident 48 had an active diagnosis of a psychotic disorder. MDS dated [DATE] indicated Resident 48 no longer had a diagnosis of a psychotic disorder. MDS stated this error wasn't caught in the medical record.</p> <p>During a concurrent interview and record review on 5/16/24 at 10:37 a.m. with Medical Records Director (MRD) Resident 48's diagnoses list in computer charting was reviewed. Resident 48's diagnoses list indicated a diagnosis of psychosis prior to hospitalization on [DATE] but not after returning to the facility on [DATE]. MRD stated the admission nurse probably failed to look at Resident 48's previous diagnoses when readmitting from the hospital. MRD stated the psychosis diagnosis should have been included in Resident 48's MR when she was readmitted and should not have been dropped off the list of active diagnoses.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Documentation Accuracy in the Health Record, (undated) the P&P indicated, INTRODUCTION Clinical records should accurately reflect the care given by each member of the health care team as well as the response of the person to receiving services. Accurate records are vital to the individual, to the staff and to the facility administrators. Coordination of this care in the records requires accurate information available to all members of the health care team.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47444</p> <p>Based on observation, interview, and record review, the facility failed to implement infection control practices when:</p> <ol style="list-style-type: none"> One of one resident's (Resident 64) wheelchair was not clean or safe for use. Housekeeping staff did not follow transmission-based precautions (TBP - guidelines for use of personal protective equipment when caring for resident with a contagious infection) for one of one sampled resident (Resident 85). Water Management Program (WMP) did not assess risk, identify areas of concern, monitor and identify measures to prevent growth of opportunistic waterborne pathogens (germs that grow well in water) within the facility's water system for all residents, staff, and visitors. Maintenance and cleaning of one of one resident's (Resident 125) resident owned C-Pap (continuous positive airway pressure - medical equipment used to assist breathing during sleep) machine was not completed and documented. <p>These failures had the potential to result in increased risk of infection, serious illness or death of the facility's residents, staff, and visitors.</p> <p>Findings:</p> <ol style="list-style-type: none"> During an observation on 5/13/24 at 9:45 a.m. in Resident 64's room, a seat cushion on Resident 64's wheelchair had a visible brown stain. <p>During a concurrent observation and interview, on 5/14/24 at 9:50 a.m. with Certified Nursing Assistant (CNA) 2, in Resident 64's room, the visible brown stain was still on the wheelchair cushion. CNA 2 stated the stain appeared to be dried stool.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Policies and Practices - Infection Control, dated October 2018, the P&P indicated, Policy Statement This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Policy Interpretation and Implementation . 2. The objectives of our infection control policies and practices are to: a. Prevent, detect, investigate, and control infections in the facility. b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public.</p> <p>During a review of the facility's P&P titled, Cleaning and Disinfection of Environmental Surfaces, dated August 2019, the P&P indicated, Environmental surfaces will be cleaned and disinfected according to current CDC [Center for Disease Control and Prevention - national health care organization] recommendations for disinfection of healthcare facilities . Policy Interpretation and Implementation . 10. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. 15. Spills of blood and other potentially infectious materials will promptly be cleaned and decontaminated.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During a concurrent observation and interview on 5/13/24 at 11:34 a.m. with Infection Preventionist (IP), outside of Resident 85's room, a Contact Precautions [requires gown and gloves to prevent spread of infection] sign hung on Resident 85's door frame. IP stated Resident 85 had been placed on contact precautions due to an eye infection.</p> <p>During a concurrent observation and interview on 5/15/24 at 8:59 a.m. with Housekeeper (HK) 1, inside Resident 85's room, HK 1 and HK 2 were wearing only masks and gloves as they cleaned Resident 85's wheelchair, bedside table, and other surfaces. HK 1 stated they (housekeeping staff) were not required to wear a gown while cleaning Resident 85's environment.</p> <p>During an interview on 5/16/24 at 8:05 a.m. with IP, IP stated housekeeping staff should have worn gowns while cleaning in Resident 85's room.</p> <p>During a review of the facility's P&P titled, Isolation - Categories of Transmission-Based Precautions, dated September 2022, the P&P indicated, Policy Statement Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Contact Precautions 1. Contact precautions are implemented for residents known or suspected to be infected with microorganisms [germs] that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. 8. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed.</p> <p>3. During an interview on 5/16/24 at 8:32 a.m. with IP, IP stated the Water Management Program (WMP) was the responsibility of the maintenance department. IP stated she does not meet with maintenance regarding the WMP and does not know what they do or how often.</p> <p>During a concurrent interview and record review on 5/16/24 at 10:05 a.m. with Director of Maintenance (DM), the Water Management Binder (WMB), was reviewed. The WMB contained a map of the water system and two policies. DM was unable to verbalize or provide documentation related to assessment of risk, identified areas of risk, and monitoring measures to prevent growth of waterborne pathogens within the facility's water system. DM stated he does not meet with IP to discuss water management. DM stated the facility does not have a water management team.</p> <p>During a review of the facility's P&P titled, Legionella [bacteria that can cause a severe respiratory infection] Water Management Program, dated September 2022, the P&P indicated, Policy Statement Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Policy Interpretation and Implementation 1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. 3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease [respiratory infection caused by Legionella bacteria] . 5. The water management program includes the following elements: a. An interdisciplinary water management team . c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria . d. The identification of situations that can lead to Legionella growth.</p> <p>(continued on next page)</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 05/16/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. During a review of Resident 125's Physician's Orders (PO), dated 3/19/24, the PO indicated, CPAP at Bedtime.</p> <p>During an interview on 5/16/24 at 3:10 p.m. with Assistant Director of Nursing (ADON), ADON stated there was no documentation that tracked cleaning and maintenance of CPAP machines.</p> <p>During an interview on 5/16/24 at 3:52 p.m. with Director of Nursing (DON), DON stated Resident 125 brought his CPAP machine from home. DON stated she does not have anyone specifically in charge of resident CPAP machines brought from home and the facility does not have a process for tracking maintenance and cleaning of those machines.</p> <p>Requested a facility P&P for maintenance and cleaning of residents' CPAP machines brought from home, none was provided.</p> <p>During a review of the facility's P&P titled, Legionella Water Management Program, dated September 2022, the P&P indicated, Policy Statement Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Policy Interpretation and Implementation . c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including the following: . (9) Medical devices such as CPAP machines.</p>		