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	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kern River Transitional Care	5151 Knudsen Drive Bakersfield, CA 93308

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46958 Based on interview, and record review, the facility failed to: 1. Follow their policy and procedure titled Psychoactive/Psychotropic Medication Use, when Informed Consents (process to ensure the provider has discussed the risks, benefits, and alternatives with the patient and the patient agrees to the provider performing the intervention) were not provided by the physician or consistently witnessed by a licensed nurse for eight of 14 sampled residents (Resident 437, Resident 111, Resident 10, Resident 338, Resident 25, Resident 8, Resident 55, and Resident 36) on psychotropic medications, (medications to treat mental health disorders). This failure had the potential for residents or their responsible party to be unaware of alternatives to medications or side effects of medications. 2. Follow their policy and procedure titled Informed Consents when Informed Consents were not provided by the physician or consistently witnessed by a licensed nurse for two of two residents (Resident 119 and Resident 91) with bed alarms (devices which sound an alarm when resident gets out of bed). This failure had the potential for residents or their responsible party to be unaware of the possisbility of residents movements to be restricted, resulting in unintended isolation, loss of strength or the development of bed sores. Findings: 1a. During a concurrent interview and record review on 4/23/25 at 3:35 p.m. with Assistant Director of Nursing (ADON), Resident 437's Initial Informed Consent-Psychoactive Medication - V 4.0 (Consent), escitalopram oxalate (to treat mental illness), dated 4/15/25 and Resident 437's Initial Consent for amitriptyline (to treat mental illness) signed by Resident 437, were reviewed. The Consents for both escitalopram oxalate and amitriptyline indicated Psychoactive Medications: Anti-depressant (medication for low mood, loss of pleasure or interest in activities for long periods of time). Neither Resident 437's Consent for escitalopram oxalate 20 milligram (mg) once a day nor Resident 437's Consent for amitriptyline 50 mg once a day indicated the physician signed the consent form. ADON stated nurses obtained consent for the medications from the family or resident in the facility. During a review of Resident 437's Admission Minimum Data Set (MDS, resident assessment tool) dated 4/19/25, Resident 437's MDS assessment under Section C indicated Resident 437 had a Brief Interview for Mental Status score (BIMS, assesses individual's attention, orientation and ability to register and recall information, a score of 0 to 7 indicates severe impairment, 8 to 12 indicates moderate impairment, 13 to 15 no impairment) of 12. (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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1b.During a concurrent interview and record review on 4/23/25 at 1:41 p.m. with ADON, Resident 111's Initial Consent for amitriptyline 75 mg at bedtime, dated 1/2/25 was reviewed. The Consent indicated Psychoactive Medications: Anti-depressant, Anti-psychotic (medications used to treat mental illness). The Consent indicated Resident 111's responsible party and a nurse signed on 1/2/25 and physician signed on 1/3/25. ADON stated nurses obtained consent for the medication from family or resident in the facility. During a review of Resident 111's Quarterly MDS, dated [DATE], Resident 111's MDS assessment under Section C indicated Resident 111 had a BIMS of 8. 1c. During a concurrent interview and record review on 4/23/25 at 1:46 p.m. with ADON, Resident 10's Initial Consent for alprazolam (to treat anxiety) 0.5 mg every 12 hours was reviewed. The Consent indicated, Psychoactive Medication s: 1 Antianxiety. The Consent did not indicate a physician signature on the consent. ADON stated the consent was incomplete. During a review of Resident 10's Quarterly MDS, dated [DATE], Resident 10's MDS assessment under Section C indicated Resident 10 had a BIMS of 3. 1d. During a concurrent interview and record review on 4/23/25 at 2:01 p.m. with ADON, Resident 338's Initial Consent for venlafaxine 75 mg 3 capsules once a day, amitriptyline 150 mg daily and Bupropion (to treat mental illness) 150 mg daily, dated 4/18/25 was reviewed. The Consent indicated, Psychoactive Medications: Anti-depressant. The Consent indicated E. Informed Consent Verification 1. A Licensed Nurse has verified the resident or resident representative has given informed consent verbally or via [by] phone Yes 1a. Date and time licensed nurse verified verbal, or phone consent was received [date and time entered], Name of person giving verbal or phone consent [Resident 338] 3. [note there is no 2. on the Consent] Signature of resident or resident representative [Resident 338 name typed in] 4. Printed name of resident or resident representative [blank] 5. Physician Signature and Date [blank] Signed by [blank] Signed Date [blank]. The Consent did not indicate either a nurse's signature or a physician signature. ADON stated the consent was incomplete. During a review of Resident 338's Admission Record AR, dated 4/18/25, the AR indicated Resident 338 was her own responsible party. During a review of Resident 338's Admission MDS, dated [DATE], Resident 338's MDS assessment under Section C indicated Resident 338 had a BIMS of 12. 1e. During a concurrent interview and record review on 4/23/25 at 2:06 p.m. with ADON, Resident 25's Consent for Sertraline (to treat mental illness), dated 4/2/25 was reviewed. The Consent did not indicate either a nurse's signature or a physician signature. ADON stated consents were incomplete. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 4/23/25 at 2:06 p.m. with ADON, Resident 25's Consent for alprazolam (medication to reduce anxiety and depression) 0.25 mg at bedtime dated 4/2/25 was reviewed. The Consent indicated, Psychoactive Medication s: 1 Antianxiety 2. Anti-depressant. The Consent indicated E. Informed Consent Verification 1. A Licensed Nurse has verified the resident or resident representative has given informed consent verbally or via phone [not indicated] 1a. Date and time licensed nurse verified verbal, or phone consent was received [blank], Name of person giving verbal or phone consent [blank] 3. [note there is no 2. on the Consent] Signature of resident or resident representative [Resident 25 name typed in] 4. Printed name of resident or resident representative [blank] 5. Physician Signature and Date [blank] Signed by [blank] Signed Date [blank]. The Consent did not indicate either a nurse's signature or a physician signature. ADON stated consents were incomplete. During a review of Resident 25's Admission MDS, dated [DATE], Resident 25's MDS assessment under Section C indicated Resident 25 had not yet had a BIMS assessment for this admission. Resident 25's MDS dated [DATE] and 3/16/25 indicated Resident 25 had a BIMS of 7. 1f. During a concurrent interview and record review on 4/23/25 at 2:14 p.m. with ADON, Resident 8's Initial Consent for Seroquel (medication for mental health condition) 25 mg at bedtime, dated 4/4/25 was reviewed. The Consent indicated Psychoactive Medications: Anti-psychotic. The Consent did not Resident 8, a licensed nurse, nor the physician signed the consent. ADON stated the consent was incomplete. During a review of Resident 8s Admission Record AR, dated 4/18/25, the AR indicated Resident 8 was his own responsible party. During a review of Resident 8's Quarterly MDS, dated [DATE], Resident 8's MDS assessment under Section C indicated Resident 8 had a BIMS of 7. During an interview on 4/23/25 at 3:17 p.m. with Registered Nurse (RN) 2, RN 2 stated nurses obtain the consent from resident or resident representative. 35649 1g. During a concurrent interview and record review on 4/23/25 at 4:30 p.m. with Director of Nursing (DON), DON was unable to find documentation of Resident 55's Informed Consent for Lorazepam (medication to treat panic disorders, anxiety and seizures) 0.5 mg. DON stated the medication was originally ordered on 3/25/25, discontinued, and reordered on 4/11/25. DON was unable to find Informed Consents for either 3/25/25 or 4/11/25. During a review of Resident 55's Order Summary Sheet (OSR, dated 4.24.25, the OSR indicated a Physician Order (PO), dated 3/25/25, indicated Lorazepam oral tablet 0.5 mg give one tablet by mouth every six hours as needed for anxiety M/B [manifested by] episodes of restlessness. Start Date: 3/25/25 DC [discontinue] Date: 4/11/25. The PO dated 4/11/25 indicated, Lorazepam 0.5 mg oral tablet give one tablet by mouth every six hours as needed for anxiety M/B episodes of restlessness for 14 days. Start Date: 4/11/25. DC Date: 4/25/25. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the Medication Administration Record (MAR) dated 4/1/25 to 4/30/25, the MAR indicated, Resident 55 received Lorazepam 0.5 mg oral tablet on 4/1/25 at 8:09 p.m., 4/9/25 at 10:42 a.m., 4/13/25 at 10:57 a.m., 4/20/25 at 8:46 p.m., 4/21/25 at 8:52 p.m., 4/22/25 at 9:12 p.m., and 4/23/25 at 7:42 p.m. During a review of Resident 55's MDS, dated [DATE] and 2/5/25, Resident 55's MDS assessment under Section C indicated Resident 55 had a BIMS of 7. 1h. During a concurrent interview and record review on 4/24/25 at 2:56 p.m. with DON, Resident 36's PO, dated 5/12/25 and 1/12/24, were reviewed. The PO dated 5/12/24 indicated, Clonazepam (medication to treat anxiety disorder and seizures) 1 mg every 12 hours for anxiety. The PO dated 1/12/24 indicated, Bupropion (antidepressant medication) 150 mg once daily for depression. During a concurrent interview and record review on 4/24/25 at 3 p.m. with DON, Resident 36's Initial Informed Consent for Bupropion, dated 1/12/24, was reviewed. The Consent indicated 1. Psychoactive Medications; 1. Anti-anxiety 2. Anti-depressant. DON was unable to find evidence Resident 36's Informed Consent for Buproprion was signed either by the resident or the resident's responsible party. During a review of Resident 36's Quarterly MDS, dated [DATE], Resident 36's MDS assessment under Section C indicated Resident 36 had a BIMS of 14. During a review of Resident 36's MAR, dated 4/1/25 to 4/30/25, the MAR indicated Resident 36 received Bupropion HCL ER (extended release) 24 hour 150 mg one tablet by mouth one time a day m/b verbalization of sadness from 4/1/25 to 4/23/25. During a review of facility's policy and procedure (P&P) titled, Psychoactive/Psychotropic Medication Use, dated 4/2025, the P&P indicated, i. The resident or resident representative has the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or to option he or she prefers. iii. Prior to administration of a psychotropic medication, the prescribing clinician will obtain informed consent from the resident (or as appropriate, the resident representative), and document the consent in the medical record. iv. A licensed nurse must verify informed consent has been obtained from the resident or the resident's representative prior to administering psychotropic medication. V. A licensed nurse must also sign the consent form, declaring that required material information has been provided. 2a. During a concurrent interview and record review on 4/23/25 at 1:54 p.m. with ADON, Resident 119's Informed Consent-Restraint - V 3.0 (IC), dated 2/26/25 was reviewed. The IC indicated, Resident 119's Bed alarm to prevent fall. The Consent indicated 4. Verbal/Phone Consent 4a. Date and time verbal/phone consent received: 5 p.m. 2/26/25 [handwritten in] 4b/ Name of person giving verbal/phone consent: [a small x and a check mark]. 5. Resident Responsible Party Signature .5c a signature and date 2/27/25. The Consent did not indicate either a nurse's signature or a physician signature. ADON stated the consent was incomplete. During a review of Resident 119's Admission MDS, dated [DATE], Resident 119's MDS assessment under Section C indicated Resident 119 had a BIMS of 6. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2b. During a concurrent interview and record review on 4/23/25 at 1:59 p.m. with ADON, Resident 91's IC dated 5/21/24 was reviewed. The IC indicated, Resident 91's Bed alarm to prevent fall. The Consent indicated verbal or phone consent was given by Resident 91's responsible party on 5/21/24 at 2:15 p.m. The Consent did not indicate either a nurse's signature or a physician signature. ADON stated the consents were incomplete. During a review of Resident 91's Annual MDS, dated [DATE], Resident 91's MDS assessment under Section C indicated Resident 91 had a BIMS of 99 (severely impaired). During a review of the facility's policy and procedure (P&P) titled, Informed Consents, revised 4/2017, the P&P indicated, 1. Resident or responsible party will be provided an informed consent when applicable. 2. When applicable, the physician will provide education to the resident or responsible party to include the risks, benefits, alternatives of a given procedure or intervention.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on interview and record review, the facility failed follow their policy and procedure (P&P) titled, Personal Property when one of one sampled resident (Resident 55) personal belongings were not recorded on the inventory sheet upon admission. This failure resulted in the loss of Resident 55's personal belongings and the potential to result in difficulty replacing the personal belongings reported as lost. Findings: During an interview on 4/21/25 at 10:42 a.m. with Resident 55, Resident 55 stated she lost two sets of pajamas and a pair of pants approximately two months ago. Resident 55 stated she told the nurses and the nursing assistants about them. Resident 55 stated, I was told they are in the pile of resident clothing. They have not been returned or replaced. During an interview on 4/23/25 at 4 p.m. with Social Services Director (SSD), SSD stated she was not aware of Resident 55's lost personal belongings. SSD stated she had not been informed. SSD stated she had not personally visited and spoken with Resident 55 about lost personal belongings. During a concurrent interview and record review on 4/23/25 at 4:10 p.m. with Director of Nursing (DON), Resident 55's Inventory of Personal Effects, dated 1/29/25, was reviewed. DON stated the staff did not complete the personal belongings inventory when Resident 55 was readmitted on [DATE]. DON stated every resident should have an inventory of their personal belongings upon admission. During a review of the facility's policy and procedure (P&P) titled, Personal Property, revised 8/2022, the P&P indicated, 10. The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 46958 Based on interview and record review, the facility failed to review and accurately complete the annual Pre-Admission Screening Assessment and Resident Review (PASARR-federal requirement to help ensure that individuals are not incorrectly placed in nursing homes or long-term care instead of a psychiatric setting) for three of 16 sampled residents (Resident 10, Resident 115, Resident 109). This failure had the potential for residents to be placed in an inappropriate setting and not receive required services. Findings: During a concurrent interview and record review on 4/24/25 at 8:31 a.m. with Director of Nursing (DON), Resident 10's PASRR [PASARR] Level I Screening, dated 12/27/24 was reviewed. The PASRR indicated, Level I positive for SMI [Serious Mental Illness]/Positive for ID [Intellectual Disability]/DD [Developmental Disability]/RC [Related Condition]. DON stated Level I was completed on 12/27/24 and it was positive for Level I screening. DON stated there was no Level II PASRR completed on Resident 10. DON stated admission nurse start the PASRR and DON was informed, and it was DON's responsibility to ensure PASRR is completed. 51320 During a concurrent interview and record review on 4/24/25 at 8:47 a.m. with DON, Resident 115's PASRR level 1 dated 3/25/25 was reviewed. PASRR level 1 was negative. Resident 115's Admission Record (AR) dated 3/27/25 was reviewed. Resident 115's AR indicated Resident 115 had unspecified psychosis (mental illness). Resident 115's Order Summary Report (OSR) dated 3/2025 was reviewed. Resident 115's OSR indicated Resident 115 was taking Risperidone (medication for mental illness). DON stated with the diagnosis and medication Resident 115's PASRR level 1 was not done accurately and therefore did not trigger a level 2 PASRR. During a review of Resident 115's PASRR level 1 screening dated 3/27/25, the PASRR level 1 indicated, the PASRR indicated, 9. Does the individual have a serious diagnosed mental disorder such as Depressive Disorder [a mental health condition characterized by persistent sadness and loss of interest], Anxiety Disorder [excessive worry, fear and other physical and behavioral symptoms that interfere with daily life], Panic Disorder [frequent and unexpected panic attacks], Schizophrenia/Schizoaffective Disorder [a chronic and severe brain disorder that disrupts a person's ability to think clearly, manage emotion, make decisions, and relate to others], or symptoms of Psychosis [a state where an individual experiences a loss of touch with reality, often characterized by hallucinations [seeing or hearing things that aren't there] and delusions [false beliefs), Delusions, and/or Mood Disturbance [significant and persistent changes in mood, energy levels, and behavior that can indicate a mood disorder]? Indicated No. The PASRR indicated, 11. The Individual has been prescribed psychotropic [drugs that affect a person's mental state] medications for mental illness. Indicated No. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/24/25 at 8:51 a.m. with DON, Resident 109 PASRR level 1 dated 3/29/25 was reviewed. PASRR level 1 was negative. Resident 109's AR dated 3/30/25 was reviewed. Resident 109's AR indicated Resident 109 had depression (mental illness) and anxiety disorder (intense excessive and persistent worry and fear about everyday situations). Resident 109's OSR, dated March 2025, indicated Resident 109 was taking Valium (medication for anxiety) and Lexapro (medication for depression). DON stated with the diagnosis and medication PASRR level 1 was not done accurately and therefore did not trigger a level 2 PASRR. During a review of Resident 109's PASRR level 1 screening dated 3/29/25, the PASRR level 1 indicated, the PASRR indicated, 9. Does the individual have a serious diagnosed mental disorder such as Depressive Disorder [a mental health condition characterized by persistent sadness and loss of interest], Anxiety Disorder [excessive worry, fear and other physical and behavioral symptoms that interfere with daily life], Panic Disorder [frequent and unexpected panic attacks], Schizophrenia/Schizoaffective Disorder [a chronic and severe brain disorder that disrupts a person's ability to think clearly, manage emotion, make decisions, and relate to others], or symptoms of Psychosis [a state where an individual experiences a loss of touch with reality, often characterized by hallucinations [seeing or hearing things that aren't there] and delusions [false beliefs), Delusions, and/or Mood Disturbance [significant and persistent changes in mood, energy levels, and behavior that can indicate a mood disorder]? Indicated No. The PASRR indicated, 11. The Individual has been prescribed psychotropic [drugs that affect a person's mental state] medications for mental illness. Indicated No. During a review of the facility's policy and procedure (P&P) titled, Admission Criteria - PASRR), dated 3/2019, the P&P indicated, If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR (sic) representative for the Level II (evaluation and determination) screening process. (1) The admitting nurse notifies the social services department when a resident is identifies as having a possible (or evident) MD, ID, or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on interview and record the facility failed to provide the completed Baseline Care Plan (BCP-initial instructions for care of the resident) Summary was provided to two of six sampled residents (Resident 72 and Resident 96) or the resident's responsible party within 48 hours of admission. This failure resulted in Resident 72 and Resident 96 or the resident's responsible party to be unaware of the plan of care during the first 48 hours. Findings: During a concurrent interview and record review on 4/23/25 at 9:44 a.m. with Director of Nursing (DON), Resident 72's Admission Record (AR), was reviewed. The AR indicated Resident 72 was admitted on [DATE]. Resident 72's BCP dated 3/26/25 was reviewed. DON was unable to find documentation Resident 72's BCP summary was provided to the resident or the resident representative. DON was unable to provide documentation of Resident 72's signature or her responsible party (RP) signature indicating receipt of the BCP summary. DON stated she did not see a signed document of the BCP summary provided to the resident or her RP within 48 hours of admission. During a concurrent interview and record review on 4/24/25 at 8:56 a.m. with Assistant Director of Nursing (ADON), Resident 96's AR was reviewed. The AR indicated Resident 96 was admitted on [DATE]. Resident 96's BCP, dated 3/25/25, was reviewed, ADON was unable to find documentation the BCP summary was provided to the resident or the resident representative. The BCP summary indicated the resident and his representative participated in the BCP review, but a copy of the BCP summary was not provided to the resident or his RP. ADON stated there was no signature indicating the resident or his RP received a copy of Resident 96's BCP summary within 48 hours of admission. During a review of the facility's policy and procedure (P&P) titled, Care Plans-Baseline, dated 12/2016, the P&P indicated, A baseline plan of care to meet the residents' immediate needs shall be developed for each resident within forty-eight (48) hours of admission . 4. The resident and the resident representative will be provided a summary of the baseline care plan that includes, but not limited to the following: a. initial goals of the residents. b. A summary of the resident's medications and dietary instructions. c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. d. Any updated information based on the details of the comprehensive care plan, as necessary.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 35649 Based on observation, interview, and record review, the facility failed to develop and implement a person-centered care plan for four of four sampled residents (Resident 72, Resident 8, Resident 110 and Resident 13). This failure had the potential for unmet care needs. Findings: During an observation on 4/21/25 at 1:13 p.m. with Resident 72, in Resident 72's room, Resident 72's left foot's skin was dry and flaky, the left toes were red and swollen, the left great (big) toenail was long, thick, yellow-orange in color, brittle and crumbly. The left 2nd, 3rd, 4th, and 5th toenails were long and the nailbeds were yellow. The skin in between the toes was blackish in color with blackish debris. there was a small wound with a dried scab, below the 4th toenail and a small wound between the left 4th toe nail and the left 3rd toe. The right foot toenails were yellow, and the nails were long. The right big toe was swollen, the toenail was deformed, yellow, with ragged edges. The right 2nd toenail was long and yellow with crumbly edges. The skin in-between the right toes was blackish in color with black debris. The skin on the right foot was dry. During a concurrent interview and record review on 4/23/25 at 9:48 a.m. with Director of Nursing (DON), Resident 72's Care Plan, was reviewed. DON was unable to provide evidence a care plan was developed and implemented for Resident 72's care of the red, swollen toes, the thick, hardened, yellowish and crumbly toenails, and the dry, flaky skin on both feet and lower extremities. DON stated there was no care plan written for Resident 72's foot care. 45654 During a review of Resident 8's, Admission Record (AR), dated 4/4/25, the AR, indicated, respiratory disorders in diseases, other specified interstitial pulmonary (scarring of the lung tissue making it difficult to breathe) diseases, acute respiratory failure with hypoxia (lungs cannot effectively transfer oxygen to the blood). During a concurrent interview and record review on 4/23/25 at 2:45 p.m. with Registered Nurse Case Manager (RNCM), Resident 8's care plans were reviewed. The facility was unable to provide documentation of an individualized care plan for acute respiratory failure with hypoxia for Resident 8. The RNCM stated she did not see a care plan for acute respiratory failure on Resident 8's care plan and the care plan should be there. 46958 During a concurrent interview and record review on 4/21/25 at 1:23 p.m. with Registered Nurse (RN) 1, Resident 110's Order Summary Report (OSR), dated 4/10/25 was reviewed. Resident 110's OSR indicated insert peripheral (in an arm) intravenous (IV, in the vein, thin tubing for administering medication or fluids directly into the bloodstream) on 4/10/25 and change the IV site every 96 hours. RN 1 stated IV should have been removed on 4/17/25. RN 1 stated IV was inserted on 4/10/25 and IV site was never changed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an concurrent interview and record review on 4/23/25 at 2:38 p.m. with Assistant Director of Nursing (ADON), Resident 110's care plans were reviewed. The facility was unable to provide a individualized care plan for peripheral IV site and care. ADON stated Resident 110 has no care plan for IV site. 32946 During a concurrent observation and interview on 4/24/25 at 2:04 p.m. in Resident 13's room. Resident 13 was lying in bed with his left arm raised above his head. Resident 13's left upper arm had gauze dressing wrapped around the left upper arm. Resident 13 stated, I have an IV. During a concurrent interview and record review of Resident 13's medical record on 4/24/25 at 2:05 p.m., with Director of Clinical Services (DCS) and Nurse Consultant (NC), the electronic medical record for Resident 13 was reviewed. DCS was unable to provide documented evidence of a care plan having been created for Resident 13's IV. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 2001, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.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.e. reflects currently recognized standards of practice for problem areas and conditions.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 46958 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) titled, Guidelines for Preventing Intravenous [in the vein] Catheter [small flexible tube to deliver fluids or medications directly into the bloodstream]-Related Infections, for two of two residents (Resident 110 and Resident 13) when IVs were not flushed (rinsed out), changed, or removed as ordered. This failure had the potential for increased risk for infection. Findings: During a concurrent observation and interview on 4/21/25 at 1:19 p.m. with Resident 110, Resident 110 had an IV in the right wrist. Resident 110 stated her last dose of IV medication was three days ago. Resident 110 stated the IV had not been flushed since the last dose of medication was administered. During a concurrent interview and record review on 4/21/25 at 1:23 p.m. with Registered Nurse (RN) 1, Resident 110's Order Summary Report (OSR), dated 4/10/25 was reviewed. The OSR indicated insert peripheral (in arm) IV on 4/10/25. The OSR indicated, Change Peripheral IV site every 96 [4 days] hours an PRN as needed. RN 1 stated the last dose of IV medication was administered on 4/16/25. RN 1 stated IV should have been removed on 4/17/25. RN 1 stated IV was inserted on 4/10/25 [11 days previosly] and the IV site was never changed. During an interview on 4/21/25 at 2:38 p.m. with Assistant Director of Nursing (ADON), ADON stated the facility expectation was to change IV site every 96 hours. ADON stated physician orders were not followed. 32946 During a concurrent observation and interview on 4/24/25 at 1:58 p.m. in Resident 13's room. Resident 13 was lying in bed with his left arm raised above his head. Resident 13's left upper arm had gauze dressing wrapped around the left upper arm. Resident 13 stated, I have an IV. During a concurrent observation and interview on 4/27/25 at 1:59 p.m. with Resident 13, Director of Clinical Services (DCS) and Nurse Consultant (NC), in Resident 13's room, an IV site to Resident 13's left upper arm was noted. Resident 13 stated he received IV antibiotics in the hospital prior to being admitted to the facility. Resident 13 stated he had not received any treatment to the IV since being admitted to this facility. Resident 13 stated he was not aware of nursing staff changing the dressing to the left arm IV site. Resident 13 stated he had been seen by a physician on 4/8/25 for his foot and the physician had provided him with a physician order to discontinue the IV. The Resident stated he had provided the physician note to a nurse when he returned from the physician visit. During a record review of Resident 13's Nursing - Admission/Readmission Evaluation/Assessment, dated 4/2/25, the Nursing - Admission/Readmission Evaluation/Assessment indicated, 1c. Resident has wounds or skin integrity concerns present on admission. B. No. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 13's Skilled Nursing History and Physical Note, dated 4/15/25, the Skilled Nursing History and Physical Note, indicated, History of Present Illness: The patient [Resident 13] has a Foley catheter and PICC [peripherally inserted central catheter - long tube inserted into the vein in the arm and threaded up to a larger vein near the heart] . Musculoskeletal: Normal ROM [range of motion] of all extremities. No lower extremity edema or cyanosis (blue tint to the person's skin). Left arm has a PICC line in place. During a concurrent interview and record review on 4/24/25 at 2:04 p.m. with DCS and NC, Resident 13's medical record was reviewed. DCS was unable to provide documented evidence of a physician order for care of the left arm IV site for Resident 13. During an interview on 4/24/25 at 2:45 p.m. with Registered Nurse (RN) 4, RN 4 stated he was unaware of Resident 13's left arm IV. RN 4 stated the IV was a Midline IV (a specialized type of IV line). RN 4 stated another (unidentified) nurse had just informed him that morning of Resident 13's Midline IV site. RN 4 stated the RNs were notified of IV's on admission. During a record review with DCS and NC of Resident 13's ORS dated 4/24/25, there was no documented evidence of a physician order regarding Resident 13's Midline IV. During a review of the facility's policy and procedure (P&P) titled, Guidelines for Preventing Intravenous Catheter-Related Infections, dated 8/2014, the P&P indicated, Promptly obtain physician order for the removal of any peripheral or central IV catheter that is no longer essential.3. A peripheral short catheter can stay in place up to 96 hours in an adult resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 35649 Based on observation, interview, and record review, the facility failed to provide necessary service for personal and oral hygiene for two of two sampled residents (Resident 72 and Resident 133) who were dependent on care being provided. This failure resulted in Resident 72 had the potential for Resident 133 to acquire oral infection, further tooth decay. Findings: 1. During an observation on 4/21/25 at 1:13 p.m. with Resident 72, in Resident 72's room, Resident 72's left foot's skin was dry and flaky the right foot skin was dry. Resident 72's toenails were long and the nailbeds were discolored. The skin in between Resident 72's toes was blackish with blackish debris. During an interview on 4/21/25 at 3:40 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 72's nails were thick and orange in color. LVN 2 stated blackish colored dirt was in-between Resident 72's toes. During an interview on 4/21/25 at 4:02 p.m. with Treatment Nurse (TN) 2, TN 2 stated she saw Resident 72 this morning. TN 2 stated she checked if Resident 72 could wiggle her toes on the left foot. TN 2 stated Resident 72 had overgrown toenails, thick nails, inverted (turned inward) in, yellow, and could be fungus. TN 2 stated Resident 72's skin was very dry, and the toes were red and swollen. TN 2 stated, I did not do anything. During an interview on 4/21/25 at 4:19 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she gave Resident 72 a shower this morning. CNA 1 stated she put a plastic bag over Resident 72's left foot with a cast so the cast did not get wet. CNA 1 stated she scrubbed the right foot with a washcloth but Resident 72 complained of pain, so she stopped. CNA 1 stated she reported to the nurse Resident 72 had pain. CNA 1 stated she was going to return to clean both of Resident 72's feet but did not do it. During a review of the facility's policy and procedure (P&P) titled, Foot Care, dated 10/2022, the P&P indicated,Residents are provided foot care and treatments in accordance with professinal standards of practice .Trained staff may provide routine foot care . 2. During a concurrent observation and interview on 4/22/25 at 10:59 a.m. with Resident 133 in Resident 133's room, Resident 133 had yellowish, gray teeth. Resident 133 stated he had a lot of dental carries and missing teeth. Resident 133 stated, There's a cavity in my molar. Resident 133 stated he had not been given mouth care yesterday and today. During a review of Resident 133's BIM (Brief Interview for Mental Status - an assessment tool to assess cognitive function of the resident. 0-7 suggests severe cognitive impairment, 8-12 indicates moderate cognitive impairment, and 13-15 suggests intact cognitive function.) Score was 10. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/24/25 at 9:27 a.m. with Assistant Director of Nursing (ADON), Resident 133's Activities of Daily Living (ADL) Oral Care, dated 4/4/25 to 4/24/25, were reviewed. The ADL Oral Care indicated the oral care for Resident 133 was completed at the following times: 4/4/25: 6:21 p.m., and 11:22 p.m. 4/5/25: 6:10 p.m. 4/7/25: 6:22 a.m., and 11:41 a.m. 4/9/25: 4:44 a.m., 10:44 a.m. 4/10/25: 4:20 a.m., and 2:28 p.m. 4/11/25: 4:34 a.m., and 6:28 p.m. 4/12/25: 3:57 a.m., and 4:38 p.m. 4/15/25: 11:31 a.m. 6/16/25: 1:11 a.m., and 3:13 p.m. 4/18/25: 3:23 p.m. 4/20/25: 1:29 p.m. 4/21/25: 4:24 a.m., and 5:24 p.m. 4/22/25: 1:19 a.m., and 6:59 p.m. 4/23/25: 1:16 a.m., and 2:28 p.m. ADON stated oral care was inconsistently provided. ADON stated resident's teeth should be brushed after every meal. ADON stated the times indicated in the ADL Oral Care were the times the certified nursing assistants had the chance to document, not necessarily the times when the oral care was rendered. ADON stated the records still indicated oral care was not consistently performed for the resident. During a concurrent interview and record review on 4/24/25 at 9:38 a.m. with ADON, Resident 133's Nursing Weekly Summary (NWS), dated 4/11/25 and 4/21/25, were reviewed. The NWS dated 4/11/25 indicated, Oral Assessment: No oral pain. ADON stated there was no assessment of the condition and appearance of Resident 133's teeth. The NWS dated 4/21/25 indicated, Oral Assessment: No oral/dental assessment. ADON stated the nursing weekly summary should reflect the condition of the resident. During an interview with Director of Nursing (DON) on 4/24/25 at 9:54 a.m., DON stated oral care should be done one to two times a shift in the morning, and once on NOC (night) shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled, Mouth Care, dated 2/2018, the P&P indicated, The purposes of this procedure are to keep the resident's lips and oral tissues [gums, tongue] moist, to cleanse and freshen the resident's mouth, and to prevent oral infection. The following should be recorded in the resident's medical record: 1. The date and time the mouth care was provided. The name and title of the individuals(s) who provided the mouth care. All assessment data obtained concerning the resident's mouth. The certified nursing assistant should report to the licensed nurse to record in the medical record.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51320 Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&P) titled Activity Program, for one of 49 sampled residents (Resident 109) when activities of interest were not provided to Resident 109. This failure resulted in Resident 109 to experience a diminished quality of life due to not participating in either individual or group activities and the potential to result in depression (sustained loss of interest). Findings: During a concurrent observation and interview on 4/21/25 at 12:06 p.m. with Resident 109 in Resident 109's room, a Certified Nursing Assistant (CNA) delivered Resident 109's lunch tray. CNA described what was in front of him on his lunch tray. Resident 109 stated he was blind in his left eye and going blind in his right eye. Resident 109 stated the facility was not giving him anything to do but sit in bed. During a review of Resident's 109's Admission Record (AR), dated 3/30/25, the AR indicated Resident 109 was admitted on [DATE] with the diagnosis including blindness to the left eye category 3 (visual field loss), normal vision right eye, unspecified glaucoma (damage to the optic nerve) and type 2 diabetes mellitus (elevated blood sugar level) with unspecified diabetic retinopathy (damage to the blood vessel in the retina [layer in the eye that detects light]) with macular edema. (swelling in part of the retina). During a review of Resident 109's Care Plan (CP) Activities [undated], the CP indicated, Provide activities materials like books, magazines, newspapers, TV, radio, arts and crafts . During a review of Resident 109's Preference for Customary Routine and Activities (Preferences) dated 4/3/25, the preferences indicated, Resident 109 enjoyed listening to music, keeping up with the news, and spending time outdoors. During a concurrent interview and record review on 4/22/25 at 12:30 p.m. with Activities Assistant (AA), Resident 109's care plan for activities was reviewed. The care plan for activities indicated resident wants materials to read. AA stated Resident 109 was unable to do those activities due to his blindness and staff would have to read to him. During a concurrent interview and record review on 4/22/25 at 12:53 p.m. with Social Services Director (SSD), Resident 109's care plan for activities was reviewed. SSD stated Resident 109's activities were not individualized for Resident 109 to meet his maximum participation in activities. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, 7.b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .d. builds on the resident's strengths (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Activity Program, dated 8/2006, the P&P indicated, Activity programs designed to meet the needs of each resident are available on a daily bases 1. Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 35649 Based on observation, interview, and record review, the facility failed to follow the facility's policy and procedures (P&P) titled, Foot Care and Social Services when nursing assessments did not indicate foot skin or nail issues, foot care was not provided and a podiatry (treatment of foot disorders, ankle, and leg) referral was not completed for one of one sampled resident (Resident 72). This failure resulted in Resident 72's left toes to be red and swollen, skin dry and flaky, right and left feet toenails to be long, thick, hard, and yellow-orange, with blackish discoloration and debris in-between the toes. Findings: During an observation on 4/21/25 at 1:13 p.m. in Resident 72's room, both of Resident 72's feet had dry and flaky skin. The left toes were red and swollen, the left great (big) toenail was long, thick, discolored, brittle and crumbly. Resident 72's left 2nd, 3rd, 4th, and 5th toenails were long, and discolored. Two small wounds were on the left 3rd toe and 4th toe. Resident 72's right foot toenails were long and discolored. The right big toe was swollen. Resident 72's big toenail was discolored and deformed with ragged edges. Resident 72's right 2nd toenail was discolored, and long with crumbly edges. The skin in-between the left and right toes was blackish with black debris. During an interview on 4/21/25 at 3:40 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 72's nails were thick and orange in color. LVN 2 stated Resident 72 had a wound on the left toe below the toenail. LVN 2 stated in-between Resident 72's toenails was blackish dirt. LVN 2 stated Resident 72 needed a podiatrist. LVN 2 stated Resident 72 had not been referred to a podiatrist. LVN 2 measured the left and right toenails with the following results: Right big toe Length (L) 1.5 centimeter (cm) Width (W): 1.5 cm Thickness (T): 1 cm 2nd right toenail: L: 0.8 cm T: 0.1 cm 3rd right toenail: L: 0.8 cm T: 0.1 cm (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4th right toenail: L: 0.9 cm T: 0.1 cm 5th right toe: L: 0.5 cm T: 0.1 cm Left big toe: L:1.5 cm T: 0.5 cm 2nd left toenail. L: 0.7 cm T: 0.1 cm 3rd left toenail: L: 0.6 cm T: 0.1 cm 4th left toenail. L: 0.9 cm T: 0.1 cm 5th left toenail. L: 0.9 cm T:0.1 cm During an interview on 4/21/25 at 4:02 p.m. with Treatment Nurse (TN) 2, TN 2 stated she saw Resident 72 this morning. TN 2 stated she checked if Resident 72 could wiggle her toes on the left foot. TN 2 stated Resident 72 had overgrown toenails, thick nails, inverted (turned inward) in, yellow, and could have fungus in her toenails. TN 2 stated Resident 72's skin was very dry, and the toes were red and swollen. TN 2 stated, I wanted to communicate with Social Services to refer Resident 72 to podiatry, but I did not do it. I did not measure the toenails this morning. I did not do anything. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/21/25 at 4:19 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she gave Resident 72 a shower this morning. CNA 1 stated she put a plastic bag over Resident 72's left foot with a cast so the cast did not get wet. CNA 1 stated she scrubbed the right foot with a washcloth but Resident 72 complained of pain, so she stopped. CNA 1 stated she was going to return to clean both of Resident 72's feet but did not do it. During a concurrent interview and record review on 4/22/25 at 9:50 a.m. with Director of Nursing (DON), Resident 72's Initial Nursing Assessment, dated 3/26/25, was reviewed. The Initial Nursing Assessment indicated, left toe warm and pink. DON stated there was no documentation about the condition of the skin, the toes, and the toenails. During a concurrent interview and record review on 4/22/25 at 9:55 a.m. with DON, Resident 72's Nursing Weekly Summary (NWS), dated 3/28/25, 4/5/25, 4/12/25, and 4/17/25 were reviewed. The NWS dated 3/28/25 indicated no new skin issue. The NWS dated 4/5/25 did not indicate documentation of skin issues and toenails. The NWS dated 4/12/25 indicated no skin issues and no mention of the toenails and skin condition. The NWS dated 4/17/25 did not indicate documentation of the skin condition, the toes, and the toenails. DON stated she did not find any assessment of Resident 72's skin condition, the appearance of the toes and the toenails. DON stated the nursing weekly summary is a summary of the previous week's condition of the resident. DON stated the nursing weekly summary did not reflect the condition of Resident 72's skin, toes, and toenails. During a concurrent interview and record review on 4/22/25 at 9:57 a.m. with DON, Resident 72's Physician Order (PO), dated 3/26/25, was reviewed. The PO indicated, Podiatry consult, and treatment as needed. DON stated there was an order for podiatry consult on admission but the order was not carried out. DON stated, I do not see any podiatry notes. DON stated there were no social services notes except one written on 4/21/25. DON stated the Social Services Social History Notes did not indicate the condition of the skin, the toes, and the toenails, and the need for podiatry consult. During an interview on 4/23/25 at 10:23 a.m. with Social Services Director (SSD), SSD stated a care conference was conducted on 4/2/25 and there was no request for ancillary (outside) services. During a concurrent interview and record review on 4/23/25 at 10:25 a.m. with DON and SSD, Resident 72's IDT (Interdisciplinary Team) Conference Summary (IDT Summary), dated 4/22/25, was reviewed. The IDT Summary did not indicate a discussion of Resident 72's skin condition, the appearance of the toes and the toenails. DON stated the IDT \Care Conference notes did not reflect Resident 72's need for foot care. SSD stated the IDT Care Conference occurred on 4/16/25. SSD stated she followed up with Resident 72 after the care conference on 4/21/25 at 5:10 p.m. and documented refusal of Resident 72 for podiatry referral four times. SSD stated she did not visit residents but wait to see them in IDT care conferences. SSD stated she did not document about the condition of Resident 72's feet as she was not a nurse. SSD stated no referral to podiatry was made. (continued on next page)

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	555912	A. Building B. Wing	04/24/2025

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Kern River Transitional Care	5151 Knudsen Drive Bakersfield, CA 93308

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Foot Care, dated 10/2022, the P&P indicated, Residents receive appropriate foot care and treatment to maintain mobility and foot health. 5. Residents with foot disorder or medical condition associated with foot complications are referred to qualified professionals. Foot disorders that require treatment include corns, neuromas (a non-cancerous growth of nerve tissue), calluses (a buildup of hard, thick areas of skin., hallux valgus (bunion-, bony bump that forms at the base of the big toe) digit flexus (hammertoe-curled toe due to a bend in the middle joint of the toe), heel spurs (bony growths that form on the underside of the heel bone, and nail disorders. During a review of the facility's P&P titled, Social Services, revised 10/2010, the P&P indicated, 4. The social services department is responsible for: d. Maintaining regular progress and follow up notes indicating the resident's response to the plan and adjustments to the institutional setting. i. Making supportive visits to residents and performing needed services (i.e., communication with the family or friends, coordinating resources and services to meet the residents' needs). k. Working with individuals and groups in developing supportive services for residents according to their individual needs and interests.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on interview and record review the facility failed to ensure: 1. Licensed nurses were competent to assess and change suprapubic catheter (thin, flexible tube inserted directly into the bladder to drain urine) for one of one sampled resident (Resident 36). 2. The facility policy and procedure titled Suprapubic Catheter Care, met Society of Urologic Nurses and Associates (SUNA) Standards of Care. This failure had the potential to result in urinary tract infections, blockage, or leakage of urine, and other complications. Findings: 1. Director of Nursing (DON), DON stated Resident 36 came to the facility on [DATE] with a suprapubic catheter due to a neuromuscular dysfunction of the bladder (bladder function is interrupted due to damage or disease affecting the nerves and muscles that control urination). During a review of Resident 36's Physician's Order (PO), dated 6/11/24, the PO indicated, Change suprapubic catheter PRN (as needed) for dislodgement [out of position], malfunction [not working], and leakage. During a concurrent interview and record review on 4/24/25 at 1:54 p.m. with DON, DON reviewed Resident 36's Treatment Record for January 2025, February 2025, March 2025, and April 2025. DON was unable to provide written documentation of when the suprapubic catheter was changed. DON stated the suprapubic catheter had not been changed for the past four months. During an interview on 4/24/25 at 2:10 p.m. with Licensed Vocational Nurse (LVN) 2 and DON, LVN 2 stated she received her training on changing suprapubic catheter while she was in school. LVN 2 stated she remembered changing Resident 36's suprapubic catheter two months ago due to leakage of urine. DON was unable to provide documented evidence LVN 2 replaced the suprapubic catheter. During a concurrent interview and record review on 4/24/25 at 2:21 p.m. with Director of Staff Development (DSD), DSD was unable to provide licensed nurse competencies on suprapubic catheter care and changing suprapubic catheter. During a review of the facility's policy and procedure (P&P) titled Suprapubic Catheter Care, dated 10/2010, the P&P indicated Documentation The following should be recorded in the resident's medical record 1. The date and time the procedure was performed. 2. The name and title of the individual(s) who performed the procedure . 2. During a review of the facility's P&P titled Suprapubic Catheter Care, dated 10/2010, the P&P did not clearly delineate who could change the catheter, the qualification and the competency of the individual who could replace or change suprapubic catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the article published by the Society of Urologic Nurses and Associates (SUNA) titled, Management of Patients after Suprapubic Catheter Insertion, Urologic Nursing / March-April 2023 / Volume 43 Number 2, the Article indicated, Specific to suprapubic catheter care [SPC] management, facilities must have a written protocol for SPC changes that clearly delineates the clinical personnel qualified to change SPCs in their institution and the training/proctoring necessary to be qualified to change SPCs. Suprapubic catheter changes are performed per the provider's order. SPC changes should be performed based on clinical signs of infection, obstruction, compromise of the closed-drainage system, or per the manufacturer's instructions for use in accordance with the regulatory scope of practice and organizational guidelines.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 45654 Based on interview, and record review, the facility failed to ensure the communication and coordination between the facility and dialysis (a procedure to remove waste products and excess fluids from the blood when the kidneys stop working) center was complete with assessment of the dialysis access site (surgically created access) on the Nursing Hemodialysis communication observation /assessment, for one of three sampled resident (Resident 79). This failure had the potential to result in complications due to having no assessment of the dialysis site. Findings: During a concurrent interview and record review on 4/26/25 at 4:25 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 79's Hemodialysis Communication Observation/Assessment (Assessment), dated 3/26/25, 3/28/25, 4/9/25, 4/11/25, 4/16/25, and 4/21/25 were reviewed. The Assessment indicated post dialysis treatment was blank. LVN 2 stated if the dialysis center does not complete the form, the facility calls the dialysis center and get the post dialysis information. During a review of the facility's policy and procedure (P&P) titled, End -Stage Renal Disease, Care of a Resident with, dated September 2010, the P&P indicated, Staff caring for residents with ESRD [end stage renal disease], including residents receiving dialysis care outside the facility, shall be trained in the care and special needs or these residents, b. the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on interview and record review, the facility failed to: 1.Ensure three of 32 sampled licensed vocational nurses (LVN 2, LVN 3, and TN 2) were competent (verified ability to perform skill) to perform care for one of one sampled resident (Resident 72) on dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). 2. Ensure three of 32 sampled licensed vocational nurses (LVN 2, LVN 3, and treatment nurse [TN] 2) were competent to provide care for one of one sampled resident (Resident 36) with suprapubic catheter (a tube inserted into the bladder to drain urine). 3. Ensure two of 14 sampled registered nurses (RN 1 and RN 3) were competent to provide care for three of three sampled residents (Resident 96, Resident 437, and Resident 187) with on Midline Catheters (thin, soft tubing, placed into a vein to deliver medications directly into the bloodstream). 4. Ensure two of 14 sampled registered nurses (RN 1 and RN 3) were competent to provide care for one of one sampled resident (Resident 34) with a Peripherally Inserted Central Catheter (PICC- a thin, flexible tube that is inserted into a large vein in the upper arm to deliver medications directly into the bloodstream). These failures had the potential for the residents to not receive the appropriate care according to evidence-based practice (quality care based on the most up-to-date research and knowledge) and standards of care (level of care that a healthcare provider is expected to provide according to evidence-based guidelines) when the facility did not ensure nursing staff competencies. Findings: 1. During a concurrent observation and interview, on 4/21/25 at 3:22 p.m. with Resident 72, in Resident 72's room, Resident 72 had an arterio-venous fistula (AV-dialysis access site) on her left upper arm. Resident 72 stated she was on dialysis and went to dialysis treatment three times a week. During a concurrent interview and record review on 4/21/25 at 4:18 p.m. with Director of Nursing (DON), the Nursing Hemodialysis Communication Observation/Assessment (NHCOA), dated 1/15/25, 3/27/25, 3/29/25, 4/3/25, 4/5/25, 4/9/25, 4/12/25, 4/17/25, and 4/22/25 were reviewed. The NHCOA forms indicated the access sites were not assessed for presence of bruit (swooshing sound indicates proper functioning of the fistula) and thrill (a vibration felt under the skin indicates good blood flow) either before or after dialysis treatment. DON stated the nurses should assess the AV site both before and after dialysis treatment. During a concurrent interview and interview on 4/23/25 at 12:05 p.m. with Director of Staff Development (DSD), LVN 2, LVN 3 and TN 2's Competency Based Orientation forms were reviewed. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Competency Based Orientation form, dated 8/2015, indicated on the first page The following symbols will be used: P = Previous experience D = demonstrated and/or instructed by the Dept [department] Head, Supervisor or Mentor/Preceptor, RD = Return Demonstration by the orienteer an or meets performance Objective NE = Needs further experience with performance objective NA = Not Applicable LVN 2 competency form, dated 10/14/24, indicated Date of Employment 8/23/22. The competency form indicated A. Provision of Nursing Care:1. Performs nursing care consistent with resident needs a check mark under P .3. Recognizes changes in resident .5. Demonstrates knowledge of unit routines .l. Outside facility appointment a check mark under P .The competency form did not indicate the facility assessed competency in dialysis. LVN 3 competency form, dated 10/14/24, indicated Date of Employment 11/9/21. The competency form indicated A. Provision of Nursing Care:1. Performs nursing care consistent with resident needs a check mark under P .3. Recognizes changes in resident .5. Demonstrates knowledge of unit routines .l. Outside facility appointment a check mark under P .The competency form did not indicate the facility assessed competency in dialysis. TN 2 competency form, dated 9/27/24, indicated Date of Employment 11/9/21. The competency form indicated A. Provision of Nursing Care:1. Performs nursing care consistent with resident needs a check mark under P .3. Recognizes changes in resident .5. Demonstrates knowledge of unit routines .l. Outside facility appointment a check mark under P .The competency form did not indicate the facility assessed competency in dialysis. DSD stated the licensed vocational nurses LVN 2, LVN 3, and TN 2 did not have completed competencies for dialysis care. 2.During an interview on 4/21/25 at 11:34 a.m. with Resident 36, Resident 36 stated he has a suprapubic catheter and a colostomy bag. During a concurrent interview and record review on 4/24/25 at 11:15 a.m. with DON, Resident 36's medical record (MR) was reviewed. Resident 36's MR indicated Resident 36 was hospitalized on [DATE] and returned to the facility on [DATE] with a suprapubic catheter for neuromuscular dysfunction of the bladder (the nerves and muscles that control urination is not working correctly). During a review of Resident 36's Physician's Order (PO), dated 6/11/24, the PO indicated, Change suprapubic catheter PRN (as needed) for dislodgement, malfunction, and leakage. DON stated the licensed vocational nurses change the suprapubic catheter. During an interview on 4/24/25 at 2:10 p.m. with LVN 2, in the presence of DON, LVN 2 stated she learned how to replace the suprapubic catheter in school. DON was unable to provide documented evidence of licensed vocational nurses' competencies on replacing suprapubic catheter and care of the suprapubic catheter. During a concurrent interview and record review on 4/24/25 at 2:21 p.m. with DSD, LVN 2's skills competency checklist dated 10/14/24, TN 2's skill competency checklist dated 9/27/24, and LVN 3's skill's competency checklist dated 10/14/24, were reviewed. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	LVN 2 competency form, dated 10/14/24, indicated Date of Employment 8/23/22. The competency form indicated 5. Catheter insertion .c. Suprapubic catheter and a check under P. There was no check under RD to demonstrate competence. LVN 3 competency form, dated 10/14/24, indicated Date of Employment 11/9/21. The competency form indicated 5. Catheter insertion .c. Suprapubic catheter and a check under P. There was no check under RD to demonstrate competence. TN 2 competency form, dated 9/27/24, indicated Date of Employment 11/9/21. The competency form indicated 5. Catheter insertion .c. Suprapubic catheter and a check under P. There was no check under RD to demonstrate competence. DSD was unable to provide documented competencies on all areas of suprapubic catheter care, catheter assessment, and catheter replacement for LVN 2, LVN 3 and TN 2. 3. During an interview on 4/24/25 at 2:38 p. m. with DON, DON stated Resident 96 had a midline catheter on the right upper arm. DON stated a nurse from a contracted company came and inserted the midline catheter on 4/8/25 on Resident 96's right upper arm. DON stated the midline catheter was used for the administration of Ceftriaxone (antibiotic). During a review of Resident 437's Medication Administration Record (MAR), dated 4/1/25 to 4/30/25, the MAR indicated, Resident 437 had a midline catheter on her left upper arm for the administration of Metropenem (antibiotic). During a review of Resident 187's MAR, dated 4/1/25 to 4/30/25, the MAR indicated, Resident 187 had a midline inserted on the left upper arm for the administration of Ertapenem Sodium (antibiotic). During a concurrent interview and record review on 4/24/25 at 2:20 p.m. with DSD, RN 1 Competency Based Orientation dated 7/13/24 and RN 3's Competency Based Orientation dated 6/27/24 were reviewed. During a review of the Competency Based Orientation form, dated 8/2015, the competency form indicated B. Administration 1. Safely administers medications by the following routes .2. IV - Hangs IV in a minimum volume . 3. Hangs on (sic) IV solutions mixed by pharmacy. 4. Checks IV solutions and labels .5. Removes IV solutions requiring refrigeration .6. Consults formulary (authorized list) of IV solutions .C. Discontinuing medication: 1. Draws diagonal line and uses yellow highlighter through medication, dose, frequency/rate, and time 2. Draws a diagonal line through and uses yellow highlighter through remaining dates in charting section .The competency form did not indicate competency in Midlines or removal of IV, Midline or Peripherally (in the arm) Inserted IV DSD was unable to provide documented evidence of RN 1 and RN 3 Midline competencies. 4. During a review of Resident 34's MAR, dated 4/1/25 to 4/30/25, the MAR indicated, Resident 34 had a PICC line for the administration of Cefazolin (antibiotic). During a concurrent interview and record review on 4/24/25 at 2:20 p.m. with DSD, RN 1's Competency Based Orientation Form, and RN 3's Competency Based Orientation Form, were reviewed. DSD was unable to provide documented evidence RN 1 and RN 3 had skills and knowledge validated for PICC line care and management. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled Licensed Nurse Competency Evaluation Guidelines, [undated], the P&P indicated, Licensed nurses must be competent in nursing skills related to the assigned and probable duties in the course of employment at the facility. For the purpose of competency evaluations: On-boarding is the introductory period of employment, generally the first 90 days. Validated prior to the nurse performing the skills independently. Annually refers to competencies validated every 12 months. Off-cycle or as needed refers to competencies that are validated based on the facility' specific care provided to the residents or used on the individual nurse needs. Documentation of the competency validations is recorded on the Licensed Nurse Master Competency Worksheet.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 46958 Based on observation, interview, and record review, the facility failed to ensure : 1. Four of five sampled residents (Resident 132, Resident 35, Resident 437, Resident 34) medications were safely and securely stored from unauthorized personnel and other resident. This failure had the potential for medication to be accessed by unauthorized staff and residents. 2. The facility policy and procedure (P&P) titled, Disposal of Medications and Medication-Related Supplies, for one of one sampled controlled substance destruction record. This failure had the potential for drug diversion. Findings: 1a. During a concurrent observation and interview on 4/21/25 at 10:29 a.m. with Licensed Vocation Nurse (LVN) 1 Resident 132 had micronazole nitrate 2% (to treat itching and burning) was found on bedside table. There was no name on the bottle. Resident 132 stated this bottle is not mine. LVN 1 stated this medication should not be here. LVN 1 stated there is no name on the bottle. During a review of Resident 132's Order Summary Report (OSR), dated 3/2025, the OSR indicated Resident 132 had no order for micronazole nitrate. During a concurrent interview and record review on 4/23/25 at 2:20 p.m. with Assistant Director of Nursing (ADON), Resident 132's clinical record (CR) was reviewed. ADON stated Resident 132 was not assessed for self-administration medication assessment. ADON stated self-administration assessment should be completed before a resident is allowed to self-administer medication. 1b. During a concurrent observation and interview on 4/21/25 at 10:37 a.m. with LVN 1 Resident 35 had eye drops (to treat dry eyes) half a bottle was found on bed side table. Resident 35 stated he received eye drops this morning. LVN 1 stated the eye drops should not be at bed side table. During a concurrent interview and record review on 4/23/25 at 2:23 p.m. with ADON, Resident 35's CR was reviewed. ADON stated Resident 35 was not assessed for self-administration medication assessment. ADON stated Resident 35 cannot keep medication at bedside. 1c. During a concurrent observation and interview on 4/21/25 at 11:10 a.m. with LVN 1 Resident 437 had moisture barrier antifungal cream (relieves and prevents rash) on bed side table. LVN 1 stated It [antifungal cream] shouldn't be in here. During a concurrent interview and record review on 4/23/25 at 2:26 p.m. with ADON, Resident 437's CR was reviewed. ADON stated Resident 437 was not assessed for self-administration medication assessment. ADON stated Resident 437 cannot keep medication at bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1d. During a concurrent observation and interview on 4/21/25 at 11:25 a.m. with LVN 1 Resident 34 had two bottles for nystatin powder (to treat fungal infection of the skin) was found on bedside table. LVN 1 stated nystatin powder shouldn't be there. During a concurrent interview and record review on 4/23/25 at 2:28 p.m. with ADON, Resident 34's CR was reviewed. ADON stated Resident 34 was not assessed for self-administration medication assessment. ADON stated Resident 34 cannot keep medication at bedside. During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2/2023, the P&P indicated, The facility stores all medications and biologicals [medications derived from organic bases] in locked compartments under proper temperature, humidity and light control, Only authorized personnel have access to keys.4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. During a review of the facility's P&P titled, Self-Administration of Medications, Dated 2/2021, the P&P indicated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so.If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status. 45654 2. During a concurrent interview and record review on 4/24/25 at 9:25 a.m. with Director of Nursing (DON) the facility's, Controlled Substance Destruction Record (Destruction Record), dated 4/22/25 was reviewed. The Destruction Record indicated, no second registered nurse signature. DON stated she told the ADON to sign but ADON forgot. During a review of the facility P&P titled, Disposal of Medications and Medication-Related Supplies, dated 2019, the P&P indicated, in the presence of two licensed nurses, and the disposal is documented on the accountability record on the line representing that dose. The same process applies to the disposal off unsealed partial tablets and unused portions of single dose ampules and doses of controlled substances wasted for any reason.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 35649 Based on observation, interview, and record review, the facility failed to assist one of one sampled resident (Resident 133) with a dental appointment. This failure had the potential for Resident 133 to acquire oral infections, further tooth decay, and gum diseases. Findings: During an observation and interview on 4/22/25 10:59 a.m. with Resident 133 in Resident 133's room, Resident 133's teeth were yellowish/gray. Resident 133 had multiple missing teeth. Resident 133 stated he had a lot of dental carries (cavities) and missing teeth. Resident 133 stated there was a cavity in his molar. Resident 133 stated, I need to be seen by a dentist badly. During a review of Resident 133's Admission Record (AR), dated 4/4/25, the AR indicated the facility admitted Resident 133 on 4/4/25. During a review of Resident 133's Order Summary Report (OSR), dated 4/24/25 the OSR indicated on 4/4/25, the physician ordered Dental consult and treatment as indicated. During a review of Resident 133's IDT [Interdisciplinary Team)] Conference Summary [IDTCS], dated 4/16/25 (12 days after admission), the social services notes indicated, The resident requested to be referred to DDS (Doctor of Dental Surgery). During a concurrent interview and record review on 4/23/25 at 10:25 a.m. with Social Services Director (SSD) and Director of Nursing (DON), DON was unable to find documentation SSD made a dental referral for Resident 133. SSD could not provide documentation she notified the dental service to ensure Resident 133 would be seen by the dentist on 4/30/25. SSD stated she had not seen Resident 133 nor contacted Resident 133 to discuss Resident 133's dental problem and the need to be seen by the dentist. During a concurrent interview and record review on 4/24/25 at 10:13 a.m. with DON, Resident 133's Social Services Social History Assessment, dated 4/4/25, was reviewed. DON stated social services did not complete the social history assessment. DON was unable to find documentation under the dental section of the assessment form of Resident 133's teeth and the need for dental referral. During a concurrent interview and record review on 4/24/25 at 10:42 a.m. with SSD, Resident 133's social history assessment, dated 4/4/25 was reviewed. SSD stated she initiated the social history assessment on 4/4/25 but she did not complete the form. SSD stated, I see there were a lot of errors and [the social history assessment is] incomplete. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Social Services, revised 10/2010, the P&P indicated, 2. Medically-related social services is provided to maintain or improve each resident's ability to control everyday physical needs (e.g., appropriate adaptive equipment, for eating, ambulation, etc .The social services department is responsible for; f. Making referrals to social service agencies as necessary or appropriate. g. Maintaining appropriate documentation of referrals and providing social services data summaries to such agencies.i. Making supportive visits to residents and performing needed services (i.e., communication with the family or friends, coordinating resources and service to meet the resident's needs).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 35649 Based on interview and record review, the facility failed to maintain a complete and accurate medical records for two of six sampled residents (Resident 72 and Resident 133) when: 1. One of one sampled resident's (Resident 72) Nursing Weekly Summary (NWS) did not accurately reflect the condition of the skin, toes, and toenail appearance. 2. One of one sampled resident's (Resident 72) Nursing Hemodialysis Communication Observation/Assessments were not completed on 3/27/25, 3/29/25, 4/3/25, 4/5/25, and 4/9/25. 3. One of one sampled resident's (Resident 133) Initial Social History Assessment was not completed. This failure had the potential to result in adverse consequences and lack of coordination and continuity of care. Findings: 1. During an observation on 4/21/25 at 1:13 p.m. in Resident 72's room, Resident 72's left foot had a short leg cast. Both of Resident 72's feet had dry and flaky skin. The left toes were red and swollen, the left great (big) toenail was long, thick, discolored, brittle and crumbly. Resident 72's left 2nd, 3rd, 4th, and 5th toenails were long, and discolored. Two small wounds were on the left 3rd toe and 4th toe. Resident 72's right foot toenails were long and discolored. The right big toe was swollen. Resident 72's big toenail was discolored and deformed with ragged edges. Resident 72's right 2nd toenail was discolored, and long with crumbly edges. The skin in-between the left and right toes was blackish with black debris. During a concurrent interview and record review on 4/22/25 at 9:50 a.m. with Director of Nursing (DON), Resident 72's Nursing Weekly Summary (NWS), dated 3/28/25, 4/5/25, 4/12/25, and 4/17/25, were reviewed. The NWS, dated 3/28/25, indicated, no new skin issues. Skin clean and intact. The NWS, dated 4/5/25, indicated, Skin: NA (not applicable). The NWS, dated 4/12/25, indicated, Skin, NA. The NWS dated 4/17/25 indicated, Skin: no skin issues. Skin clear and intact. DON stated the weekly nursing summary was a description of the previous week's skin condition. DON stated the nursing documentation was not accurate and did not reflect the true condition of Resident 72's skin, toes, and toenails. 2. During a concurrent interview and record review on 4/21/25 at 4:18p.m. with DON, the Nursing Hemodialysis Communication Observation/Assessment (NHCOA), dated 3/27/25, 3/29/25, 4/3/25, 4/5/25, 4/9/25 were reviewed. The NHCOA dated 3/27/25 indicated, the Dialysis Center documentation during Resident 72's dialysis treatment was incomplete: No assessment of access site, no medication administered if any. The licensed nurse at the facility did not complete the post-dialysis assessment; the post-dialysis section on the form was left blank and not completed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHCOA dated 3/29/25 indicated, the Dialysis Center documentation during Resident 72's dialysis treatment was incomplete: No assessment of the access site, no pan level documented, if any, no documentation of medications administered. The licensed nurse did not complete the post-dialysis assessment. The section to be completed by the licensed nurse post-dialysis was blank. The NHCOA dated 4/3/25 indicated, the licensed nurse did not complete the pre-dialysis assessment section on the form. The physician's name, the access site, the access site location, the access site assessment, time of last meal were not completed. The licensed nurse at the facility did not complete post-dialysis assessment. The access type, the access site location, the access site assessment, pain level, arrival time post dialysis was not completed. The NHCOA dated 4/5/25 indicated, The resident's name, the room, the physician's name, the access site type, the access site location, the assessment of the access site, and Arterio-venous (AV) fistula (surgically created connection between the arteries and the vein for dialysis access) assessment including thrill (palpable vibration over the access site which indicates good blood flow), pain level, time of last meal, Resident 72's general condition were not completed. The Dialysis Center documentation during dialysis was not completed. The licensed nurse at the facility did not conduct a post-dialysis assessment and the post-dialysis treatment form was not completed. The NHCOA dated 4/9/25 indicated, the pre-dialysis treatment form was incomplete. The physician's name was omitted, access site type, access site location, assessment of the AV fistula for presence of bruit (whooshing sound heard with a stethoscope that indicates blood is moving freely in the access site) and thrill, medication, time of last meal, diet, and the general condition of the resident prior to dialysis were not completed. The Dialysis Center's documentation during dialysis was left blank and not completed, the post dialysis assessment was incomplete except for the vital signs. DON stated the licensed nurses should assess the resident prior to dialysis treatment, before leaving the facility, and when the resident arrives from dialysis treatment, the licensed nurses should conduct a post-dialysis treatment assessment. DON stated the Dialysis Center staff should also document following dialysis treatment. The licensed nurses should call the Dialysis Center if the form was not completed. 3. During a concurrent interview and record review on 4/24/25 at 10:13 a.m. with DON, Resident 133's Initial Social History Assessment, dated 4/4/25, was reviewed. DON stated social services started Resident 133's initial social history assessment, but the initial social history assessment was not completed. During an interview on 4/24/25 at 11 a.m. with Social Services Director (SSD), SSD stated she initiated the initial social history assessment, but she did not complete the initial assessment for Resident 133. During a review of the facility's policy and procedure (P&P) titled, Social Services, revised 10/2010, the P&P indicated, 4. The social services department is responsible for: a. Obtaining pertinent social data about personal and family problems related to the resident's illness and care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Documentation Accuracy in the Health Record, [undated], the P&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. For a resident, the clinical record should ensure continuity of care; for the staff, it assists in coordination of services and serve as proof of work done. The clinical record is also a legal document. In litigation, the accurate recording of the facts of the situation is the best defense, not only for the individual practitioner, but also for the health care facility.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51320 Based on interview and record review, the facility failed to follow its policy & procedure (P&P) titled Binding Arbitration Agreement (BAA, resolve disputes between healthcare providers and residents) for two of twenty sampled residents (Resident 337 and Resident 115) when Admission Coordinator (AC), had Resident 337 and Resident 115 sign their BAA without understanding the legal implications. This failure resulted in Resident 337 and Resident 115 to not fully understand the legal document they signed. Findings: 1. During a concurrent interview and record review on 4/23/25 at 11:05 a.m. with AC, Resident 337's BAA dated 2/14/25 was reviewed. The BAA indicated, Resident 337 signed the BAA. Resident 337's clinical record (CR) was reviewed and indicated the following: A. Resident 337's Minimum Data Set (MDS - resident assessment tool), dated 1/31/25, the MDS indicated Resident 1 had a Brief Interview for Mental Status (BIMS, score of 9, a score of 0-7 means severe impairment, 8- 12 is moderate cognitive impairment, 13 to 15 is cognitively intact). B. Resident 337's admission note, dated 2/15/25, the admission notes indicated, Resident is alert and oriented x 3 (oriented to time, place and date) with episodes of confusion and verbally responsive. C. Resident 337's Admission Record (AR), dated 2/15/25 the AR indicated Resident 337's was own responsible party. D. Resident 337's Diagnosis Information (DI) undated, DI indicated Resident 337's was diagnosed with Dementia (memory loss and loss of ability to perform daily living skills) . AC stated she looked at the nurses' notes and diagnoses to determine if the resident can understand. AC stated she just asked Resident 337 the basic questions. AC stated she did not see in the nursing assessment that Resident 337 had confusion. 2. During a concurrent interview and record review on 4/23/25 at 11:09 a.m. with AC, Resident 115's BAA dated 4/4/25 was reviewed. The BAA indicated, Resident 115 signed the BAA. During a concurrent interview and record review on 4/23/25 at 11:10 a.m. with AC, Resident 115's AR dated 3/27/25 was reviewed. The AR indicated, Resident 115's son was the responsible party (RP) and Resident 115's spoken language was [NAME]. AC stated she did not document that she used a translator. AC stated the RP did not sign the BAA. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled Translation and/or Interpretation of Facility Services dated 2020, the P&P indicated, This facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility. During a review of the facility's policy and procedure (P&P), titled Binding Arbitration Agreements, dated 2023, the P&P indicated, Residents (or representatives) are informed of the nature and implications of any proposed binding arbitration agreements so as to make informed decisions on whether to enter into such agreements. 5. The terms and conditions of a binding arbitration agreements are explained to the resident (or representative) in a way that ensures his or her understanding of the agreement . the resident or representative must acknowledge that he or she understands the agreement before being ask to sign the document.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on interview and record review, the facility failed to ensure Social Services Director (SSD) met the required qualifications to manage and coordinate social services for 126 residents living in the facility and to fulfill the duties of the SSD. This failure had the potential to result in residents not being referred to appropriate social service agencies for their needs, required social services assessments performed and completed timely, accurate documentation and follow-up with residents and resident representatives of the residents' social service's needs, and ensure the residents could attain and maintain highest practicable physical, mental, or psychosocial well-being. Findings: During an interview on 4/23/24 at 10:23 a.m. with Social Services Director (SSD), SSD stated she was new to the facility. She stated her educational qualification included a Bachelor of Science Degree in Psychology, currently working on her master's in social work. SSD stated her work experience included social work in mental health. SSD stated this is her first experience working with residents in a skilled nursing facility. During a concurrent interview and record review on 4/23/25 at 10:30 a.m. with Director of Nursing (DON) and SSD, social services activities for the residents were reviewed. SSD was informed of the issues observed throughout the course of the survey. The following social services had not been facilitated: Advance Directive information had not been provided to six of six sampled residents (Resident 72, Resident 55, Resident 36, Resident 47, Resident 96, and Resident 133) or the resident representatives. (Cross-reference to F658). Dental referral for one of one sampled resident (Resident 133) had not been made for a resident admitted on [DATE]. A physician order dated 4/4/25 indicated dental referral. (Cross-reference to F790). Podiatry referral for one of one sampled resident (Resident 72) had not been made for Resident 72 who showed signs and symptoms of foot problem, possible fungal infection, and toenail deformity. (Cross-refence to F687). SSD stated she had not visited one of one resident (Resident 133) who expressed concerns about his mail and his ability to pay his bill. SSD stated she does not do resident visits in the room but waits for the residents in care conferences. SSD stated she does not do just-in-time documentation. SSD stated she documents after two days in medical records. SSD had not completed Resident 133's Initial Social History Assessment to determine Resident 133's needs. (Cross-reference to F842). The Notice of Transfer and Discharge to the Ombudsman (representatives who assist residents in long-term care facilities with issues related to day-to-day care, health, safety and personal preferences) for one of six sampled resident's (Resident 40) was not completed and sent to the Ombudsman. SSD stated it was not her responsibility to notify the Ombudsman. (Cross-reference to F623). Three of 16 sampled residents (Resident 10, Resident 109, and Resident 115 had not been appropriately assessed and referred for Pre-admission Screening and Resident Review (PASRR-federal requirement to help ensure that individuals are not incorrectly placed in nursing homes or long-term care instead of a psychiatric setting). The facility's policy and procedure (P&P) titled Admission Criteria, dated 2019, indicated The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID, or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority. DON stated she was aware of these occurrences as she had been able to verify them throughout the interview and record review with SSD. (continued on next page)

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of SSD's Job Description, dated 2/2024, the Job Description indicated, Essential Duties: Assist the residents in achieving the highest practicable level of self-care, independence, and well-being. Provide medically-related services so that the highest practicable physical, mental, and psychosocial well-being of each resident is attained or maintained. Assist in inventory and tracking of patient belongings. Assist in obtaining resources from community and social services agencies as well as health and welfare agencies to meet the needs of the resident. Assist in discharge planning with appropriate agencies, entities or individuals to include agency services equipment, and agency referrals. Coordinate with interdisciplinary teams. During a review of the facility's policy and procedure (P&P) titled, Social Services, the P&P indicated, The director of social services is a qualified social worker and is responsible for: b. Consultation to allied professional health personnel regarding provisions for the social and emotional needs of the residents in the facility.d. An adequate record system of obtaining, recording, and filing of social services data. f. Assistance in meeting the social services and emotional needs of residents.4. The social services department is responsible for: a. Obtaining pertinent social data about personal and family problems, related to the resident's illness and care. B. Identifying individual social and emotional needs.d. Maintaining regular progress and follow up notes indicating the resident's response to the plan and adjustment to the institutional setting.f. Making referrals to social services agencies as necessary or appropriate.i. Making supportive visits to residents and performing needed services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 51320 Based on observation, interview, and record review, the facility's Quality Assurance and Performance Improvement (QAPI, process to identify problems and initiate improvement processes) committee failed to identify on-going issues, develop, and implement corrective action plans for Infection Prevention and Control practices (F636, F655, F656, and F868) and Social Services (F658, F790, F687, F842 and F623) not provided as identified by the survey team. These failures placed all 126 facility residents at risk for acquiring infectious diseases and not receiving medically necessary services. Findings: During a concurrent interview and record review on 4/24/25 at 3:09 p.m. with the Administrator, the minutes of the facility's QAPI (a committee that identifies quality deficits and implements corrective plans) meeting dated 4/18/25 and 1/19/25 were reviwed. The Administrator stated meetings were held every Tuesday to review new residents assessments. The facility's deficient practices reviewed included failure to assess each resident and care planning of residents. The Administrator stated the above resident assessment deficient practices had not been identified by the facility and were not covered during the most recent (F636, F655, F656, and F880) QAPI meeting. During an interview on 4/24/25 at 3:13 p.m.with the Administrator, Administrator stated previous Social Services Director (SSD) was not competent in job duties and was let go in December of 2024. Administer stated the Director of Nursing had taken on duties and our admission records are reviewed every Tuesday. Administer stated we are at 100% compliance. During a review of the facility policy and procedure (P&P) titled Quality Assurance and Performance Improvement (QAPI) program dated February 2020, the P&P indicated, This facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI Program that is focused on indicators of the outcome of care and quality of life for our residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 51320 Based on interview and record review, the facility failed to ensure the facility's Infection Preventionist (IP) attended two of three sampled Quality Assessment and Performance Improvement (QAPI, committee that identifies quality deficits and implements corrective plans) committee's meetings during 2024 and 2025. This failure had the potential for the facility to not be aware of infection control issues and develop a plan to address infection control issues. Findings: During a concurrent interview and record review on 4/24/25 at 3:09 p.m. with the Administrator, the QAPI committee sign in sheets dated 9/24/245, 1/19/25, and 4/18/25 were reviewed. The Administrator stated the IP attends the QAPI meetings. Administrator was unable to verify IPs attendance at the QAPI meetings on 9/24/245 and 4/18/25 with the QAPI attendance sheets. The Administrator stated the QAPI committee met September 2024, January 2025, and April 2025. The sign in sheet dated, 9/24/24 indicated the following signatures: Administrator, Director of Nursing (DON), Business Office Manager (BOM), Director of Staff Development (DSD), Minimum Data Set (resident assessment tool) Coordinator (MDS), Medical Records (MR), (Environmental Services (EVS) Supervisor, and Medical Doctor (MD). The sign in sheet dated, 1/19/25 indicated the following signatures: Administrator, DON, Assistant Director of Nursing (ADON), MD, DSD, MDS, MR, Director of Rehabilitation (DOR), Social Services Director (SSD), BOM, EVS Supervisor, and IP. The sign in sheet dated, 4/18/25 indicated the following signatures: Administrator, DON, BOM, DOR, and four illegible signatures.

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	04/24/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 35649 Based on observation, interview, and record review, the facility failed to follow and implement the Center for Disease Control and Prevention (CDC, nationally recognized health organization) infection control practices when: 1. Licensed Vocational Nurse (LVN) 2 did not follow Enhanced Barrier Precaution (EBP, precautions to reduce transmission of infectious organisms) protocols during closed contact with one of one sampled resident (Resident 72). 2. The X-ray Technician (XRT) stepped out of the room with contaminated gloves and isolation gown to answer a phone call after in close contact with one of one resident (Resident 96) on EBP. 3a. Treatment Nurse (TN) 1 threw the contaminated dressing with serosanguinous (thin, watery, and pinkish red in color fluid from a wound) drainage onto a regular trash bin. 3b. TN 1 did not perform hand hygiene before putting on a new pair of gloves. 3c. TN 1 used a pair of unsterile (free from germs) pair of scissors to cut the sterile not packing strip during wound packing for one of one sampled resident (Resident 96). 4. Central Supply Staff (CS) 1 accessed a disinfectant wipe container without a lid with her hand. These failures had the potential to cause cross-contamination and transmit infectious diseases to other residents, staff and visitors. Findings: 1. During a concurrent observation and interview on 4/21/25 at 3:40 p.m. with LVN 2 in Resident 72's room, Resident 72 had a wound on the right ankle. Signage was posted on the wall indicated Resident 72 was on EBP. LVN 2 put on a pair of gloves but did not wear an isolation gown. LVN 2 measured the left and right toenails without required Personal Protective Equipment (PPE- refers to gowns, gloves, masks, goggles, face shield worn to protect the individual from infection or injury). LVN 2 stated Resident 72 was on EBP and stated she should have worn a gown, but she did not. During a review of Resident 72's Physician Order (PO), dated 4/16/25, the PO indicated, Requires Enhanced Barrier Precautions. During a review of the facility's policy and procedure (P&P) titled, Isolation-Transmission-Based Precautions & Enhanced Barrier Precautions, revised 9/2023, the P&P indicated, The facility has a framework for reducing MDRO [multi-drug resistant organism] transmission through staff use of gowns and gloves while caring for patients at high risk for MDRO transmission at the point of care during specific activities. 1. Wear gowns and gloves while performing the following high-contact tasks associated with the greatest risk for MDRO contamination of staff hands, clothes, and the environment such as: c. Any care activity where close contact with the resident is expected . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During an observation on 4/22/25 at 11:34 a.m. in Resident 96's room, with Administrator, the X-Ray Technician (XRT) entered Resident 96's room to take x-rays of Resident 96. Signage posted indicated Resident 96 was on EBP precautions. XRT had gloves on and an isolation gown on during the procedure. XRT stepped out of the room with his contaminated gloves and isolation gown to answer a call on his cell phone. The Administrator saw XRT step out of Resident 96's room, still wearing gloves and isolation gown while using his cell phone in the hallway. XRT returned to Resident 96's room, removed his gown and gloves, but did not perform hand hygiene prior to touching the x-ray machine and re-exiting Resident 96's room. During an interview on 4/22/25 at 11:41 a.m. with XRT, XRT stated he did not remove his gloves and gown when he stepped out of the room to answer the phone call. XRT also stated he did not perform hand hygiene when he exited the room. During a review of the facility's P&P titled, Isolation-Transmission-Based Precaution & Enhanced Barrier Precaution, revised 9/2022, the P&P indicated, e. Gowns and gloves should always be removed inside the room when the care activity is complete. Gowns and gloves should not be worn outside of the room when resident care is not being performed. 3a. During a concurrent observation and interview on 4/22/25 at 12 p.m. with Treatment Nurse (TN) 1 and TN 2, in Resident 96's room, TN 1 and TN 2 entered Resident 96's room to clean and change Resident 96's wound dressing on the left leg. With gloves and gown on, TN 1 removed the old dressing and stated Resident 96 has an open wound on the left shin resulting from a ruptured hematoma. TN 1 stated the wound was draining serosanguinous fluid. After cleaning the wound with normal saline, TN 1 disposed of the contaminated dressing onto the regular trash bin. TN 1 stated there was no biohazard bin inside the room. 3b. During an observation on 4/22/25 at 12:05 p.m. with TN 1 in Resident 96's room, TN 1 removed the contaminated gloves and put on a new pair of gloves without performing hand hygiene. TN 1 irrigated the wound with normal saline and started to prepare for the wound packing (specialized techniques for deep wounds to encourage healing). 3c. During a concurrent observation and interview on 4/22/25 at 12:10 p.m. with TN 1 in Resident 96's room, TN 1 used a pair of non-sterile scissors to cut a sterile strip of gauze for wound packing. With the same gloves on used during wound irrigation, TN 1 soaked the sterile strip of gauze into a cup with Daikin (a strong topical antiseptic widely used to clean infected wounds, ulcers, and burns) solution and then put the wet sterile strip of gauze inside the wound. After the procedure, TN 1 stated he disinfects the scissors after using them. TN 1 stated he cut the sterile strip of gauze with the scissors and the used gauze were discarded. During a review of the facility's P&P titled, Wound Care, revised 10/2010, the P&P indicated, 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry hands thoroughly. During a review of the facility's P&P titled, Handwashing/Hand Hygiene, revised 10/2023, the P&P indicated, Administrative Practices to Promote Hand Hygiene: 2. All personnel are expected to adhere to hand hygiene policies and practices to prevent spread of infection to other personnel, residents, and visitors.Indications for Hand Hygiene: 1. Hand Hygiene is indicated for: c. after contact with blood, body fluids, or contaminated surfaces. d. after touching a resident. f. before moving from work on a soiled body site to a clean body site on the same resident g. immediately after love removal. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	45654 During a concurrent observation and interview on 4/21/25 at 12:35 p.m. with Central Supply (CS), in hallway A, CS wiped a resident's oxygen contractor machine (machine increases the percentage of oxygen in room air) with a Sani Cloth (wipes, sanitizing and disinfecting wipe). There was no lid on top of the Sani Cloth container. CS stated I just wiped down the concentrator and the lid should be placed back on the Sani wipes. During an interview on 4/24/25 at 10:44 a.m. with IP, IP stated no the staff member should not have the top off the Sani wipe container that was not an acceptable practice.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 46958 Based on interview and record review, the facility failed to ensure that 108 out of 108 sampled Certified Nursing Assistants (CNAs) were attending at least 5 hours of dementia (a loss of mental function)-specific in-service training on an annual basis. This failure had the potential for CNAs to be uneducated how to meet care need of residents with dementia. Findings: During a concurrent interview and record review on 4/23/25 at 9:09 a.m. with Director of Staff Development (DSD), Dementia Mod [module] 4 (DM 4), dated 6/12/24 was reviewed. The DM 4 attendance sheet indicted 35 out of 108 CNAs attended dementia training. DSD stated only 35 CNAs attended the one-hour Dementia training. During a concurrent interview and record review on 4/23/25 at 9:11 a.m. with DSD, Dementia Review Annual (DRA), dated 8/23/24 were reviewed. The DRA attendance sheet indicated 60 out of 108 CNAs attended dementia training. DSD stated only 60 CNAs attended the one-hour training. During a concurrent interview and record review on 4/23/25 at 9:13 a.m. with DSD, DM 4 dated 9/19/24 was reviewed. The DM 4 attendance sheet indicated 56 out of 108 CNAs attended dementia training. DSD stated only 56 CNAs attended the one-hour training. During a concurrent interview and record review on 4/23/25 at 9:15 a.m. with DSD, DM 3 dated 9/29/24 was reviewed. The DM 3 attendance sheet indicated 68 out of 108 CNAs attended dementia training. DSD stated only 68 CNAs attended the one-hour training. During a concurrent interview and record review on 4/23/25 at 9:17 a.m. with DSD, DM 1 attendance sheet dated 1/21/25 was reviewed. The DM 1 indicated 35 out of 108 CNAs attended dementia training. DSD stated only 35 CNAs attended the one-hour training. During a concurrent interview and record review on 4/23/25 at 9:19 a.m. with DSD, Dementia attendance sheet dated 4/2/25 was reviewed. The Dementia attendance sheet indicated 33 out of 108 CNAs attended dementia training. DSD stated only 33 CNAs attended the one-hour training. During a review of the facility's policy and procedure (P&P) titled, In-Service Training, All Staff, dated 2001, the P&P indicated, All staff must participate in initial orientation and annual in-service training.2.For the purpose of this policy, staff means all new and existing personnel.(3) dementia management and resident abuse prevention.