STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555912	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** Based on interview and record review, the facility failed to promptly notify the attending physician and one of three sampled resident's (Resident 1) representative after Resident 1 had an unwitnessed fall and sustained bruising and swelling over left eye, cheek, and forehead. This failure had the potential for a delay in treatment. Findings: During an interview on 7/29/20, at 11:55 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 7/9/20 at approximately 7:15 AM she was given report Resident 1 had swelling to her left eye. She stated Resident 1 was sleeping at the time so she could not visualize Resident 1's eye. LVN 1 stated at 8:15 AM she was able to visualize Resident 1's face and noted Resident 1's left eye, cheek, and forehead were very swollen with red to purple discoloration. LVN 1 stated a certified nursing assistant (CNA) informed her Resident 1's roommate stated Resident 1 had an unwitnessed fall about 4:30 AM on 7/9/20. LVN 1 stated she was not given this information during the shift change. During an interview on 8/6/20, at 9:32 PM, with LVN 2, LVN 2 stated on 7/9/20 about 4 AM he heard a resident yell out. He stated when he entered Resident 1's room Resident 1 was found sitting on the floor in front of her roommate's bed. LVN 2 stated Resident 1 denied hitting her head and had no visible injuries at that time. LVN 2 stated, I am not sure if I notified the MD, I did not notify the family. I did not call, it was way too early. LVN 2 stated, I don't think I gave report to oncoming nurse. During a concurrent interview and record review on 8/20/20, at 2:28 PM, with the Director of Nursing (DON), the DON stated it is her expectation the nurses assess the resident and notify the physician immediately after a fall to obtain orders. The DON stated during interviews with LVN 2 he confirmed he did not notify Resident 1's physician or responsible party, nor did he endorse Resident 1's fall to the oncoming nurse (LVN 1) on 7/9/20. During a review of the facility's policy and procedure (P&P) titled, Change in Resident's Condition or Status revised 5/17, the P&P indicated, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition . 1. The nurse will notify the resident's Attending Physician or physician on call when there has been . a. accident or incident involving the resident; . 4. Unless otherwise instructed by the resident, a nurse will notify the resident representative when: a. The resident is involved in any accident .
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently assess the neurological status (brain and nerve function) for one of three sampled residents (Resident 1). This had the potential for neurological harm to go unnoted which could result in a delay in treatment. Findings: During an interview on 7/29/20, at 11:55 AM with LVN 1, LVN 1 stated on 7/9/20 at approximately 7:15 AM, she was given report Resident 1 had swelling to her left eye. She stated Resident 1 was sleeping at the time so she could not visualize Resident 1's eye. LVN 1 stated around 8:15 AM she was able to visualize Resident 1's face. She stated Resident 1's left eye, cheek, and forehead were very swollen with red to purple discoloration. LVN 1 stated a certified nursing assistant (CNA) informed her that Resident 1's roommate stated Resident 1 had an unwitnessed fall about 4:30 AM that morning. LVN 1 stated she was not given this information during shift change. LVN 1 stated neurological checks (NC - assessment of brain and nerve function) should have been complete per schedule: every 15 minutes for the first hour, every 30 minutes for 1 hour, every hour for the next 4 hours, and every 4 hour until 72 hour is complete after an unwitnessed fall. LVN 1 stated she could not assess Resident 1's left pupil due to swelling and that Resident 1 was drowsy. During an interview on 8/6/20, at 9:32 PM, with LVN 2, LVN 2 stated on 7/9/20 about 4 AM he heard a resident yell out. He stated when he entered Resident 1's room Resident 1 was found sitting on the floor in front of the roommate's bed. LVN 2 stated Resident 1 denied hitting her head and had no visible injuries at that time. LVN 2 stated it is facility protocol to initiate NC after an unwitnessed fall. LVN 2 stated he started NC right away. LVN 2 stated, I don't think I gave report to oncoming nurse (about the fall and NC). During a concurrent interview and review of the clinical record for Resident 1, on 8/20/20, at 2:28 PM, with the DON, the DON reviewed Resident 1's NCs dated 7/9/20. The DON confirmed no NC were completed from 6:30 AM to 10 AM (3.5 hours). The DON stated NC are important for detecting changes in mental status and are early indicators of possible [MEDICAL CONDITION]. She stated it is her expectation that NC are preformed consistently. The DON stated LVN 2 stated in a post fall interview, he did not endorse the fall or NC to on coming nurse (LVN 1). During a review of the facility's policy and procedure (P&P), revised 10/10, titled Neurological Assessment, the P&P indicated, The purpose of this procedure is to provide guidelines for a neurological assessment: 1) upon physician order; 2) when following an unwitnessed fall . Steps in the Procedure . 3. Perform neurological checks with the frequency as ordered or per fall protocol.
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** Based on interview and record review, the facility failed to follow their policy and procedure (P&P) for Foley Catheter (FC- is a flexible tube inserted into the bladder to drain urine) Removal for one of three sampled residents (Resident 1). This failure has the potential to lead to infection. Findings: During an interview on 8/6/20, at 2:25 PM, with the Director of Nursing (DON), the DON stated when a resident or family member request that a FC be removed, the physician must be contacted to obtain an order for [REDACTED]. RN 1 confirmed she removed Resident 1's FC on 7/19/20. She was unsure the reason Resident 1 had the FC. RN 1 stated Resident 1's daughter called the facility and complained about the FC and requested the FC be removed. RN 1 stated the facility procedure is to notify the resident's physician and get an order prior to removal of the FC. RN 1 was unable to provide documentation the physician was notified or that an order was obtained for the removal of the FC. RN 1 stated, I might not have put the order in. I am sorry there is no order for removal. During a review of the facility's P&P titled, Foley Catheter Removal, revised 10/10, the P&P indicated, Preparation 1. Verify that there is a physician's order for this procedure.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.