STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555336	A. BUILDING _____ B. WING _____	**09/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINGSTON HEALTHCARE CENTER, LLC	**329 REAL ROAD BAKERSFIELD, CA 93309**

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 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy and procedure (P&P) for pain management for one of three sampled residents (Resident 1) when Resident 1's pain level was not assessed before and after pain medication was administered per the facility's P&P. This failure had the potential for excessive pain medication or inadequate pain relief for Resident 1. Findings: During an interview on 6/18/20, at 1:55 PM, with Resident 1, Resident 1 stated, she needed to go back to bed because of the pain to her back and her right leg. Resident 1 stated, she fell last night and hurt her leg. Resident 1 stated, she asked Licensed Nurse (LN) 1 for pain medication. Resident 1 stated, Licensed Nurse 1 told her she only had pain medications ordered every four hours. During a concurrent interview and record review on 6/18/20, at 2:15 PM with LN 2 and the Director of Nursing (DON), at the nurses' station, Resident 1's Medication Administration Record [REDACTED]. LN 2 stated, she administered [MEDICATION NAME] to Resident 1 on 6/18/20, at 9 AM. During a concurrent interview and record review on 6/18/20, at 2:20 PM with LN 2 and the DON, at the nurses' station, Resident 1's Pain Assessment Flow Sheet was reviewed. LN 2 stated, she had not completed the post pain assessment after Resident 1 received [MEDICATION NAME] on 6/18/20 at 9 AM. During a concurrent interview and record review on 7/10/20, at 2:47 PM with Director of Staff Development (DSD), Resident 1's Medication Administration Record [REDACTED]. The following were noted: On 6/1/20, the MAR indicated [REDACTED]. There was no documented evidence a pain assessment was done before or after the pain medication was administered. On 6/2/20, the MAR indicated [REDACTED]. There was no documented evidence a pain assessment was done before or after one dose of pain medication. On 6/3/20, the MAR indicated [REDACTED]. There was no documented evidence a pain assessment was done before or after one dose of pain medication. On 6/4/20, the MAR indicated [REDACTED]. There was no documented evidence a pain assessment was done before or after one dose of pain medication. On 6/5/20, the MAR indicated [REDACTED]. There was no documented evidence of any pain assessments done before or after the pain medication was administered. On 6/6/20, the MAR indicated [REDACTED]. There was no documented evidence a pain assessment was done before or after one dose of pain medication. On 6/7/20, the MAR indicated [REDACTED]. There was no documented evidence a pain assessment was done before or after one dose of pain medication. On 6/8/20, the MAR indicated [REDACTED]. There was no documented evidence a pain assessment was done before or after two doses of pain medication. On 6/9/20, the MAR indicated [REDACTED]. There was no documented evidence of any pain assessments done before or after the pain medication was administered. On 6/10/20, the MAR indicated [REDACTED]. There was no documented evidence of any pain assessments done before or after the pain medication was administered. On 6/13/20, the MAR indicated [REDACTED]. There was no documented evidence a pain assessment was done before or after one dose of pain medication. On 6/14/20, the MAR indicated [REDACTED]. There was no documented evidence of any pain assessments done before or after the pain medication was administered. On 6/15/20, the MAR indicated [REDACTED]. There was no documented evidence of any pain assessments done before or after the pain medication was administered. On 6/16/20, the MAR indicated [REDACTED]. There was no documented evidence a pain assessment was done before or after two doses of pain medication.DSD confirmed the discrepancies in Resident 1's clinical record. During a review of the facility P&P titled Pain Management, dated 11/16, the P&P indicated, Pain Assessment . After medications/interventions are implemented, the licensed nurse will reevaluate the resident's level of pain within one hour. Pain Management . Nurses will complete the Pain Flow Sheet for residents receiving PRN pain medication to evaluate the effectiveness of the medication regimen
F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** Based on interview and record review, the facility failed to ensure the drug regimens for three of three sampled residents (Resident 1, Resident 2 and Resident 3) were reviewed by the Consulting Pharmacist (CP) at least monthly. This failure had the potential for drug irregularities to go unnoticed. Findings: During a concurrent interview and record review on 7/10/20, at 2:41 PM, with DON, the clinical records for Resident 1, Resident 2 and Resident 3 were reviewed. DON was unable to provide documented evidence the CP had reviewed Resident 1, Resident 2 or Resident 3's drug regimens between 1/20 and 6/20.

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