STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555116	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Health Facility	1401 New Stine 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 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37697 Based on interview and record review, the facility failed to provide safe transportation for one of three sampled residents (Resident 1). This failure resulted in Resident 1 being dropped off alone at a wrong address and had the potential for harm. Findings: During a review of Resident 1 ' s Minimum Data Set (MDS- an assessment tool) under the section BIMS (Brief Interview for Mental Status - an assessment of cognition [mental processes including perception, memory, and thought]), dated 9/10/24, the BIMS indicated, Resident 1 had a score of 4 (severe cognitive impairment). During a review of Resident 1 ' s ADMISSION RECORD (AR), dated 10/15/24, the AR indicated, Resident 1 was a [AGE] year-old male with the following diagnosis: a. Hemiplegia (weakness or inability to move one side of the body) and Hemiparesis (inability to move the arm, leg, and trunk of one side of the body) following cerebral infarction (loss of blood flow to part of the brain) affecting the right dominant side. b. Memory deficit following cerebral infarction (lack of blood flow to part of the brain). c. Cognitive communication deficit (difficulty communicating due to cognition issues). d. Dysphagia (difficulty swallowing). e. Lack of coordination. f. Need for assistance with personal care. g. Chronic pain syndrome (a condition that involves consistent pain). During a review of Resident 1 ' s MDS under the section GG (an assessment of the level a care a resident requires), dated 9/10/24, the GG indicated, Resident 1 required: a. Resident one had impairment to one side of his body for upper and lower extremities. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Resident 1 required maximum assistance from staff to sit up in bed. c. Resident 1 required maximum assistance from staff to go from a sitting position to standing. d. Resident 1 was unable to be assessed due to medical condition or safety concerns when transferring in and out of a car. e. Resident 1 was unable to be assessed due to medical or safety concerns to wheel himself 50 feet in a wheelchair and make two turns. During an interview on 10/15/24 at 1:19 p.m. with Social Services Director (SSD), SSD stated Resident 1 discharged suddenly per family request after he went out to an eye appointment on 10/4/24. SSD stated the facility transported Resident 1 to the eye appointment. SSD stated she found it unusual to have a request for discharge while a resident was out on an appointment. During an interview on 10/15/24 at 1:54 p.m. with Transportation Supervisor (TS), TS stated on 10/4/24, she transported Resident 1 to his eye appointment where he was to meet his family member. TS stated when she arrived at the eye appointment Resident 1 ' s family member was not there to meet him, so she dropped off Resident 1 in front of the building and went back to transport other residents in the building with appointments the same day. TS stated she was later called by Resident 1 ' s family member and realized she had dropped off Resident 1 at the wrong address. TS stated she contacted SSD about dropping Resident 1 off at the wrong address. TS stated, It was my mistake I dropped him (Resident 1) off at the wrong address. TS stated she was not informed by the facility when a resident cannot be left alone or was in need of someone to be with them. During an interview on 10/15/24 at 2:02 p.m. with SSD, SSD stated she was informed on 10/4/24 by Resident 1 ' s case manager he was dropped off on his own at the wrong address. SSD stated due to Resident 1 ' s cognition and need for assistance he should have had someone with him. During an interview on 10/15/24 at 2:11 p.m. with Administrator, Administrator stated Anything and everything (should be) communicated about the resident. Especially if they are to meet a family member or escort. If no one is there to meet them call home (facility) and get further instruction. Administrator stated residents in need of an escort should not be left alone on appointment due to their cognition and chance for elopement (leaving a healthcare facility without authorization or supervision putting health and/or safety at risk). During a review of the facility ' s policy and procedure (P&P) titled, TRANSPORTATION, not dated, the P&P indicated, It is the policy of this facility to assist residents in accessing transportation according to their needs. Social Services staff works with other members of the Interdisciplinary Team to determine a resident ' s need for transportation. A resident may also request assistance with transportation. Any special considerations pertaining to transportation, such as limitations or preferences, should be documented in the resident ' s clinical record.