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	02/11/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37697 Based on interview and record review, the facility failed to ensure the Interdisciplinary team (IDT- a group of professionals from different fields in the nursing facility that work together to address a patient's needs) met to discuss if one of three sampled residents (Resident 1) who was high risk for falls (move downward, typically rapidly and freely without control from a higher to a lower level), had a history of falls, and had a diagnosis of Dementia (a progressive state of decline in mental abilities), was safe to have one-on-one monitoring (1:1- a type of care where a healthcare professional provides constant supervision to a resident) discontinued. After discontinuing the 1:1 monitoring the facility failed to conduct a fall risk assessment (medical evaluation used to determine how likely a resident is to fall), update the care plan (CP- a document that outlines a resident's needs, treatment, and expected outcomes) to include updated interventions, and provide adequate supervision. These failures resulted in Resident 1 sustaining a fall with fracture (broken bone), experiencing pain and requiring admission with surgical intervention (a medical procedure that involves physically altering the body to treat or prevent a medical condition) at the acute hospital. Findings: During a review of Resident 1's ADMISSION RECORD (AR), dated 2/11/25, the AR indicated, Resident 1 was admitted to the facility on [DATE]. The AR indicated Resident 1 had diagnosis of history of falling, Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia, and spinal stenosis (a narrowing of the spinal column that occurs over time and can put pressure on the spinal cord [a tube-shaped bundle of nerves that runs from the brain to the lower back]) lumbar region (lower back) with neurogenic claudication (a condition that causes pain, weakness, or numbness in the legs while walking or standing), need for assistance with personal care, and difficulty in walking. During a review of Resident 1's admission Minimum Data Set (MDS- an assessment tool) under the section Brief Interview for Mental Status (BIMS- an assessment of cognition [how well a person thinks, remembers, and learns]), dated 1/13/25, the BIMS indicated, Resident 1 had a score of 3 (very low level of cognition [how well a person thinks, remembers, and learns] function). The MDS under the section GG (an assessment of the level a care a resident required), dated 1/13/25, the GG indicated, Resident 1 required supervision or touching assistance to move from a sitting to standing position, move from chair to bed or bed to chair, pick up objects from the floor from a standing position due to medical condition and/or safety concerns. (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
	555116	A. Building B. Wing	02/11/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Fall Risk Evaluation (FRE), dated 1/9/25, the FRE indicated, Resident 1 had a score of 19 (high risk for falls). During a review of Resident 1's CP dated 1/9/25, the CP indicated, to anticipate and meet Resident 1's needs. During a review of Resident 1's Progress Notes (PN), dated 1/28/25, the PN indicated, Resident 1 had an unwitnessed fall at approximately 9:25 p.m. (on 1/28/25) and complained of right knee pain. The PN indicated on 1/29/25, Resident 1 was sent to the acute hospital due to complaint of right knee pain. During a review of the acute hospital ED (Emergency Department) Physician Notes (EDPN), dated 1/29/25, the EDPN indicated, Pt (Patient- Resident 1) BIBA (brought in by ambulance) for fall. Pt (Resident 1) is from (facility) and had an unwitnessed fall at the Nurses station around 2100 (9 p.m.) last night. Pt (Resident 1) is complaining of Right Knee/Hip/Lower back pain (no specific pain information given) from the fall. The patient (Resident 1) is a female with history of dementia . During a review of the acute hospital History and Physical (H+P), dated 1/29/25, the H+P indicated, Resident 1 had, frequent falls . who presents to the hospital after having a ground-level fall at (facility). The patient (Resident 1) was in a wheelchair when she fell forward out of the wheelchair landed on her right side. (Resident 1) was complaining of right-sided pain (no specific information given about pain) . X-ray (medical imaging technique that uses radiation to create a picture of the inside of the body) is positive for a right comminuted (producing multiple bone splinters) intertrochanteric (hip) fracture. The EDPN indicated Resident 1 was given morphine (narcotic [pain medication] medication for severe pain) four mg (milligram- a unit of measurement) in the ED. During a review of the acute hospital Discharge Summary (DC), dated 2/1/25, the DC indicated, Patient (Resident 1) was taken the (sic) OR (Operating Room) for (surgical procedure) intramedullary (hollow center of the bone) nailing (a metal rod placed into the bone to stabilize a break) of the right femur (thigh bone). Medications to Continue . acetaminophen-Hydrocodone (a narcotic drug) . 5 mg -325 mg oral (by mouth) tablet . 2 (tablets) every 6 hours as needed for severe pain. During an interview on 2/11/25 at 2:26 p.m. with Director of Nursing (DON), DON stated Resident 1 had an unwitnessed fall in front of the nurse's station on 1/28/25 at approximately 9:25 p.m. DON stated Resident 1 was at the nurse's station at the time of the fall due to Resident 1 being confused (exhibiting an inability to understand) and needing to be monitored/supervised closely by staff to prevent falls. During an interview on 2/11/25 at 3:33 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 was confused and attempting to get out of her wheelchair or bed without assistance. CNA 1 stated staff would place Resident 1 at the nursing station to monitor/supervise due to her high risk for falls. CNA 1 stated staff would place Resident 1 in her bed when she was exhausted to rest and sleep. CNA 1 stated Resident 1 used to be on 1:1 monitoring (not sure of the dates) but it was discontinued (not aware by who) prior to her fall incident on 1/28/25. CNA 1 stated on 1/28/25 she was at the nurse's station, Resident 1 was behind her (approximately five feet- [unit of measurement]), but she was not monitoring/supervising Resident 1. CNA 1 stated she heard a loud noise, turned around, and observed Resident 1 lying on the floor. (continued on next page)

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	02/11/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/11/25 at 3:45 p.m. with CNA 2, CNA 2 stated Resident 1 had a 1:1 monitoring (not sure of the dates) but no longer on 1:1 monitoring at the time of the fall on 1/28/25. CNA 2 stated she was about three feet away from Resident 1 prior to her fall (1/28/25) but was not directly monitoring/supervising Resident 1. During an interview on 2/11/25 at 4:03 p.m. with Nursing Supervisor (NS), NS stated prior to Resident 1's fall incident on 1/28/25, Resident 1 was on 1:1 monitoring to prevent falls (not sure of when the 1:1 started and when was it discontinued). NS stated on 1/28/25, Resident 1 was found lying on the floor and complained of right leg pain. NS stated the facility process was to place high risk residents on 1:1 monitoring, If they (residents) are a really high fall risk (for falls) and staff . express (they) are not able to keep up (with the resident). During a review of Resident 1's Electronic Medical Record (EMR), on 2/11/25 at 1 p.m., there was no evidence the facility conducted an IDT meeting to discuss if Resident 1 was safe to have the 1:1 monitoring discontinued, there was no fall risk evaluation (FRE), and there was no updated care plan noted after discontinuing the 1:1 monitoring for Resident 1. During a concurrent interview and record review on 2/20/25 at 1:10 p.m. with Administrator, Resident 1's EMR, dated 1/2025 was reviewed. Administrator stated Resident 1 was started on 1:1 monitoring on 1/11/25 due to staff being overwhelmed with Resident 1 trying to get up without assistance. Administrator stated the 1:1 monitoring was discontinued on 1/17/25. Administrator stated the facility did not conduct an IDT meeting to discuss if Resident 1 was safe to have the 1:1 monitoring discontinued, there was no fall risk evaluation (FRE) done until after the fall incident on 1/28/25, and there was no updated care plan for updated interventions. Administrator stated there should have been an IDT done to discuss if Resident 1 was safe enough to come off 1:1 monitoring, fall risk assessment and updated CP. Administrator stated the staff (not identified) last observed Resident 1 on 1/28/25 at 8:54 p.m. and the unwitnessed fall happened at 9:25 p.m. (31 minutes after last observation). During an interview on 2/25/25 at 9:41 a.m. with CNA 3, CNA 3 stated she was assigned to Resident 1 on the day she fell on [DATE]. CNA 3 stated Resident 1 was on 1:1 monitoring in the past (not sure of the dates). CNA 3 stated prior to the fall incident on 1/28/25 Resident 1 attempted to get up without assistance at least four times by the nurse's station and at least twice in her room (from 2:30 p.m. to 9 p.m.). CNA 3 stated she was helping another resident when Resident 1 fell on [DATE]. CNA 3 stated she had not asked any other staff member to monitor/supervise Resident 1 because, We (staff) all knew to put her in the nurse's station and monitor her (Resident 1). During a review of the facility's policy and procedure (P&P) titled, Care Planning- Interdisciplinary Team, dated 3/2022, the P&P indicated, The interdisciplinary team is responsible for the development of resident care plans. During a review of the facility's P&P titled, Fall Risk Assessment, dated 3/2018, the P&P indicated, The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. (continued on next page)

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	02/11/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's P&P titled, Falls and Fall Risk, Managing, dated 3/2018, the P&P indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Resident conditions that may contribute to the risk of falls include . cognitive impairment (how well a person thinks, remembers, and learns) . Resident-Centered Approaches to Managing Falls and Fall Risk .