

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2025
NAME OF PROVIDER OR SUPPLIER  Rosewood Health Facility		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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:  555116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2025
NAME OF PROVIDER OR SUPPLIER  Rosewood Health Facility		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to develop and implement a noncompliance care plan (CP- documents the resident's needs based on an identified problem, documents interventions necessary to be implemented by the whole healthcare team to meet the established goal) for one of three sampled residents (Resident 1) identified as a high risk for developing pressure injuries (PI-is localized damage to the skin and underlying soft tissue usually over a bony prominence). This failure resulted in Resident 1 developing an unstageable pressure injury (obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the PI cannot be confirmed because it is obscured by slough [yellow or white material consisting of dead cells which attaches to the wound bed] or eschar [dead tissue that forms over healthy skin]. If slough or eschar is removed, a Stage 3 [Full-thickness loss of skin, in which adipose (fat) is visible] or Stage 4 [Full-thickness skin and tissue loss with exposed muscle, tendon [flexible tissue, similar to a rope], ligament [a band of tissue that connects bones, joints or organs], cartilage [a strong, flexible connective tissue that protects joints and bones] or bone are visible in the pressure injury] are revealed) to the coccyx (tailbone) and a deep tissue injury (DTI - intact or non-intact skin with localized area of persistent non-blanchable [the skin does not turn white when touched with a finger] deep red, maroon, purple discoloration or epidermal [outer layer of skin] separation revealing a dark wound bed or blood-filled blister [raised skin filled with fluid]) to the right heel. Findings: During a review of Resident 1's admission Record, (AR) the AR indicated, Resident 1 was admitted on [DATE], with diagnoses included wedge compression fracture of T-9 and T-10 vertebra (is a break in a vertebra [bones in your spine]) and end stage renal disease (kidney disease that progresses to a point where the kidneys lose nearly all their ability to filter waste from the body). During a review of Resident 1's Minimum Data Set, (MDS - an assessment tool) dated 8/11/25, the MDS indicated, Resident 1' s BIMS (Brief Interview for Mental Status-standardized assessment tool used to evaluate the mental processes that allow individuals to think, learn, and remember) score was 15 (13 to 15 points indicates the resident has cognitive intactness) The MDS indicated Resident 1 was dependent (helper does all the effort) for toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement), roll left and right (the ability to roll from lying on back to left and right side, and return to lying on back on the bed), and sit to lying (the ability to move from sitting on side of bed to lying flat on the bed). The MDS indicated Resident 1 did not have pressure injuries upon admission. The MDS indicated Resident 1 was at risk for developing pressure injuries. During a review of Resident 1's Braden Scale for Predicting Pressure Ulcer Risk Evaluation, (Braden) dated 8/26/25, the Braden indicated Resident 1 scored a 11 (score of 10-12 indicated resident 1 was at a high risk for developing a pressure injury). During a review of Resident 1's Clinical admission (CA), dated 8/26/25, the CA indicated, Skin: Skin warm &amp; dry, Skin color WNL (within normal limits) and turgor (the skin's elasticity and its ability to return to normal after being gently pinched, serving as a key indicator for assessing hydration) is normal. Skin note: open scabs to R (right) lateral (towards the side of the body or away from the middle) thigh, scabs to BLE (bilateral [both sides] lower extremities [arms and legs]) and BUE (bilateral upper extremities), skin peeling to R (right) foot, old amputation (surgical removal of a limb or body part) of all digits (toes) to R (right) and L (left) foot. During a review of Resident 1's care plan (is a comprehensive, personalized document that outlines the specific needs of an individual requiring care, detailing the type of support, how it will be provided, and the goals of the care) with the focus on The resident has an ADL self-care performance deficit r/t (related to) Limited Mobility, Limited ROM, Musculoskeletal impairment . , initiated 8/21/25, The care plan indicated a few of the interventions were Bed Mobility: The resident is totally dependent on 1-2 staff for repositioning and turning in bed 3-4 times a shift and as necessary, The resident is bedfast all or most of the time, and Personal Hygiene/Oral Care: The resident is totally dependent on 1 staff for personal hygiene and oral care. During a review of Resident 1's care plan with the focus on The resident has risk of potential for pressure injury development r/t immobility, initiated 8/22/25. The care plan indicated a few of the interventions were to The resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested, Monitor nutritional status. Serve diet as ordered. Monitor intake and record. and Treat pain as per orders prior to treatment/turning. to ensure The [sic] resident's comfort. During a review of Resident 1's Documentation Survey Report, (DSR) for September 2025 the DSR indicated the following: On 9/2/25 at 7 a m the DSR indicated Resident 1 refused</p>		