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	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Health Facility	1401 New Stine Road Bakersfield, CA 93309

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 45654 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled Resident Informed Consent for the use of Psychotherapeutic [medication to treat mental disorders] Drugs, for two of six sampled residents (Resident 48 and Resident 217) when their informed consents were not complete. This failure had the potential for Resident 48 and Resident 217 to receive psychotropic medication without knowing the risks and benefits of the medication. Findings: During an interview on 11/6/24 at 2:06 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated the doctor was responsible for getting the informed consent and the nurse was the one who witnessed the resident's signature. During a review of Resident 48's Physician Orders (PO) dated 5/16/23, the PO indicated, Temazepam (used to treat inability to sleep) 15 mg capsule, 1 capsule through the feeding tube (tube inserted into stomach for nutritional and medication needs) one time daily. During a review of Resident 48's Informed Consent (IC) dated 5/19/23, the IC indicated This documentation is to be completed before treatment is initiated which chemical restraints, physical restraints, phsychotherapeutic drug .The IC indicated Resident 48 had a Resident Representative. The IC did not indicate the Resident Representative had signed the consent, and there was no signature by a facility representative. 46958 During a review of Resident 217's Order Review History Report (ORHR), dated 11/4/24, the ORHR indicated Resident 217 was receiving Temazepam 15 mg capsule, 1 capsule by mouth at bedtime and Mirtazapine (used to treat depression) 45 mg 1 tablet by mouth at bedtime. During an interview on 11/7/24 at 3:20 p.m. with Registered Nurse (RN) 1, RN 1 stated Resident 217's IC were incomplete. During a review of the facility's policy and procedure (P&P) titled, Resident Informed Consent for the use of Psychotherapeutic Drugs, dated 4/4/24, the P&P indicated, Before receiving treatment with a psychotherapeutic drug the facility must verify that this consent is signed and, [sic] in the individual's, [sic] medical record.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40516 Based on observation, interview, and record review, the facility failed to update the care plan for for one of three sampled residents (Resident 20). This failure resulted in Resident 20 developing Moisture Associated Skin Damage (MASD- caused by prolonged exposure to various sources of moisture). Findings: During an observation on 11/4/24 at 10:42 a.m. two staff members repositioned Resident 20. Resident 20 was non-verbal. During a review of Resident 20's Admission Record (AR), the AR indicated diagnoses including, weakness or the inability to move on the left side of her body, severe loss of strength on the left side of her body, inability to talk, and obesity. During a concurrent interview and record review on 11/6/24 at 11:06 a.m. with Director of Nursing (DON), Resident 20's Care Plan (CP), revision date of 9/27/24, was reviewed. The CP indicated two staff were to reposition Resident 20 at least once a shift and as necessary. DON stated dependent residents are turned every two hours and as needed. DON stated Resident 20's CP should have been updated to turn every two hours after she was diagnosed with MASD on 10/24/24 and that there was no reason for the CP to not be updated. During an interview on 11/6/24 at 3:40 p.m. with DON, DON stated if a resident is not turned, pressure injuries and skin breakdown will occur.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 45654 46958 Based on interview and record review, the facility failed to ensure physician ordered medication was available for one of six sampled residents (Resident 217). This failure resulted in Resident 217's pain not being controlled as evidenced by Resident 217's statement of pain of 6 to 7 out of 10 (on a 10 point pain scale 0 is no pain, 1-3 mild pain, 4-6 moderate pain, 7-9 severe pain, 10 unbearable pain). Findings: During an review of Resident 217's Physician Order (PO), dated 11/1/24, Glucosamine-Chondritin Tablet (used to treat joint pain) 500mg-400 mg give 2 tablet by mouth two times a day. During a concurrent interview and record review on 11/7/24 at 8:23 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 217's Medication Administration Record (MAR), dated November 2024 was reviewed. The MAR indicated the following: 11/2/24 a.m. shift medication was not administered. 11/2/24 p.m. shift medication was not administered. 11/3/24 a.m. shift medication was not administered. 11/3/24 p.m. shift medication was not administered. 11/4/24 a.m. shift medication was not administered. 11/5/24 a.m. shift medication was not administered. 11/5/24 p.m. shift medication was not administered. 11/6/24 a.m. shift medication was not administered. 11/6/24 p.m. shift medication was not administered. LVN 1 stated medication was not available to administer and when when medication was not available the pharmacy should be notified. During an interview on 11/7/24 at 8:34 a.m. with Resident 217, Resident 217 stated when I move, I have pain of 6 to 7 in my left knee. During an interview on 11/7/24 at 4:02 p.m. with Director of Nursing (DON), DON stated expectation is for new admission medication should be available within 4-6 hours and if it is over the counter medication than facility can buy from a local pharmacy. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an review of Resident 217's Progress Note (PN), dated 11/7/24, the PN indicated the Pharmacy would not deliver medication due to the medication being over the counter(OTC). A policy for notifying the physician when medication was not available to administer was requested, none was provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 40516 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) titled, Repositioning for one of three sampled residents (Resident 20). This failure resulted in Resident 20 developing Moisture Associated Skin Damage (MASD- caused by prolonged exposure to various sources of moisture). Findings: During an observation on 11/4/24 at 10:42 a.m. two staff members repositioned Resident 20. Resident 20 was non-verbal. During a review of Resident 20's Admission Record (AR), the AR indicated diagnoses including, weakness or the inability to move on the left side of her body, severe loss of strength on the left side of her body, inability to talk, and obesity. During a concurrent interview and record review on 11/6/24 at 11:06 a.m. with Director of Nursing (DON) stated dependent residents are turned every two hours and as needed. Care Plan (CP) with a revision date of 9/27/24 was reviewed. The CP indicated two staff were to reposition Resident 20 at least once a shift and as necessary. DON stated Resident 20's CP should have been updated to turn every two hours after she was diagnosed with MASD on 10/24/24 and that there was no reason for the CP to not be updated. During a concurrent interview and record review on 11/6/24 at 12:01 p.m. with DON and Assistant Minimum Data Set Coordinator (AMDSC), Resident 20's Documentation Survey Report (DSR) dated November 2024 was reviewed. The DSR indicated the following: 11/1/24 Turned/Repositioned at 8:15 a.m. and 4:11p.m. 11/2/24 Turned/Repositioned at 11:09 a.m. and 6:51 p.m. 11/3/24 Turned/Repositioned at 10:31 a.m. and 6:33 p.m. 11/4/24 Turned/Repositioned at 11:15 a.m. and 5:17 p.m. 11/5/24 Turned/Repositioned at 2:11 p.m. and 6:03 p.m. AMDSC and DON unable to find documentation of Resident 20 being turned on the night shift (10 p.m. to 6:30 a.m.). DON stated there was no other documentation of Resident 20 being turned more than once per shift. During an interview on 11/6/24 at 3:40 p.m. with DON, DON stated if a resident is not turned, pressure injuries and skin breakdown will occur. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled Repositioning dated 2001, the P&P indicated, The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents . General Guidelines 1. Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. 2. Evaluation of a resident's skin integrity after pressure has been reduced or redistributed should guide the development and implementation of repositioning plans. Such plans should be addressed in the comprehensive plan of care consistent with the resident's needs and goals. 3. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning . Interventions .3. Residents who are in bed should be on at least an every two (q 2 hour) repositioning schedule . Documentation The following information should be recorded in the resident's medical record: 1. The position in which the resident was placed. This may be on a flow sheet.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 40516 Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&P) titled Catheter Care, Urinary, for one of two sampled residents (Resident 49) when timely nursing assessment and interventions were not provided when Resident 49 complained of pain. This failure resulted in Resident 49 experiencing discomfort. Findings: During a concurrent observation and interview on 11/4/24 at 9:43 a.m. with Resident 49, in his room, a catheter (flexible tube that continually drains and empties urine from the bladder into a collection bag outside the body) urine collection bag was seen suspended from the left side of his bed. Resident 49 stated he had the catheter because he had a lot of kidney stones (small, hard deposits that form in the kidneys and are often painful when passed) and a lot of sediment (the material from a liquid that settles to the bottom) drained from his urine. During an interview on 11/5/24 at 9:56 a.m. with Resident 49, he stated he was having pain from his catheter, and he made his nurse aware of the discomfort. Resident 49 stated his nurse told him something was going to be done about the catheter discomfort. During an interview on 11/5/24 at 11:03 a.m. Resident 49 stated no one had done anything about the pain from the catheter site and he was still having pain. During an interview on 11/5/24 11:05 a.m. Licensed Vocational Nurse Supervisor (LVNS), LVNS stated she was covering for LVN 2, who was Resident 49's nurse. LVNS stated LVN 2 was at lunch. LVNS stated she would check with LVN 2 to find out what was happening with Resident 49's catheter issues. During an interview on 11/5/24 at 11:10 a.m. with LVNS, LVNS stated LVN 2 was aware of Resident 49's catheter pain and LVN 2 was going to tell Treatment Nurse (TN) about Resident 49's catheter discomfort. LVNS stated any licensed nurse could assess catheter issues, not just TN. During a record review on 11/5/24 at 11:20 a.m. Resident 49's medical record was reviewed, the medical record indicated, no nurse's notes regarding Resident 49's catheter discomfort. During a record review on 11/5/24, Resident 49's Order Summary (PO-physician orders) dated 8/11/24 was reviewed. The PO indicated, an indwelling catheter was to be placed to relieve urinary retention (inability to urinate) and be changed as needed when catheter stops draining, becomes dislodged, or leakage occurs. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/5/24 at 11:30 a.m. with LVN 2, LVN 2 stated Resident 49 complained of pain from his catheter. LVN 2 stated Resident 49 told her his catheter was leaking from the placement area (tip of the penis). LVN 2 stated she looked in the urine collection bag and saw it was draining. LVN 2 stated she did not assess Resident 49 for a reason the catheter caused Resident 49 discomfort. LVN 2 stated she should have assessed for a reason for the discomfort but did not because his tray [meal tray] was in front of him. LVN 2 stated she was going to tell TN about Resident 49's catheter discomfort, but stated she should have assessed the reason for the pain herself. LVN 2 stated she medicated Resident 49 with Tylenol. During an interview on 11/5/24 11:47 a.m. with TN, TN stated she assessed Resident 49's catheter discomfort. TN stated it was leaking from the tip of the penis. TN stated she replaced the catheter and immediately drained 300 ml of urine (people will feel the need to urinate (pee) when their bladder has between 150 and 250 ml of urine in it) with a little bit of sediment. TN stated Resident 49 stated he felt better once the catheter was replaced. During an interview on 11/5/24 at 12:28 p.m. with Resident 49, Resident 49 stated he felt better after the catheter was replaced. Resident 49 stated he felt a lot of pressure before it was replaced. During an interview on 11/7/24 at 11:40 a.m. with Director of Nursing (DON), DON stated LVN 2 should have completed a focused assessment to determine what caused Resident 49's catheter discomfort. During a review of the facility's policy and procedure (P&P) titled Catheter Care, Urinary, the P&P indicated, The purpose of this procedure is to prevent urinary catheter-associated complications . Complications 1. Observe the resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately . d. if the resident complains of burning, tenderness, or pain in the urethral area [in men- tube that carries urine from the bladder to the tip of penis]. e. if signs and symptoms of urinary tract infection or urinary retention occur [condition that makes it difficult to empty the bladder, either partially or completely].

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 46958 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Psychotropic Medication Use, for one of seven sampled residents (Resident 217), when the facility did not monitor changes in behavior and side effects for physician ordered medications, Mirtazapine (to treat depression) and Temazepam (to treat inability to sleep). This failure had the potential to affect the health and safety of Resident 217. Findings: During a concurrent interview and record review on 11/6/24 at 11:52 a.m. with Assistant Director of Nursing (ADON), Resident 217's Order Review History Report (ORHR), dated 11/4/24 was reviewed. The ORHR indicated, Resident 217 was on Mirtazapine 45 mg 1 tablet by mouth at bedtime. ADON stated the facility was not monitoring for behavior changes and no monitoring for side effects of Mirtazapine. Licensed nurses administered four doses of Mirtazapine to Resident 217 between 11/2/24-11/5/24 in p.m. During a concurrent interview and record on 11/6/24 at 11:54 a.m. with ADON, Resident 217's ORHR, dated 11/4/24 was reviewed. The ORHR indicated, Resident 217 was on Temazepam 15 mg capsule, 1 capsule by mouth at bedtime. ADON stated the facility was not monitoring for behavior changes and no monitoring for side effects of Temazepam. Licensed nurses administer four doses of Temazepam to Resident 217 between 11/2/24-11/5/24 in p.m. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated 2001, the P&P indicated, Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotics; b. Anti-depressants; c. Anti-anxiety medications; and d. Hypnotics. 3. Residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes: . d. adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying and responding to adverse consequences.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46958 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) titled, Medication Labeling and Storage for two of 32 sampled residents (Resident 219, Resident 58) and two of two medication carts when: 1. Medications were at the bedside for two of 32 sampled residents (Resident 219, Resident 58). This failure had the potential for medication to be accessed by unauthorized staff and residents. 2. Four of 14 insulin (medication to lower sugar levels in the blood) vials were expired on two of two sampled medication carts. This failure had the potential to result in a loss of medication potency (strength), inaccurate test results, and adversely affect the residents' health. Findings: 1. During a concurrent observation and interview on [DATE] at 10:52 a.m. with Licensed Vocational Nurse (LVN) 2 in Resident 219's room, Resident 219 had Calazinc (helps protect and relieve minor skin irritation due to rashes) on the bedside table. LVN 2 stated medication should not be at bedside. During a concurrent observation and interview on [DATE] at 1:15 p.m. with LVN 2 in Resident 58's room, Resident 58 had Vitamin A&D ointment (used for skin irritation such as diaper rash and skin burns from radiation therapy). LVN 2 stated Vitamin A&D should be applied by nurses. During a concurrent interview and record review on [DATE] at 11:32 a.m. with Assisted Director of Nursing (ADON), Resident 219's Medical Record (MR), was reviewed. The MR indicated, Resident 219 had no self-medication assessment done and had no physician order to keep medication at bedside. ADON stated Resident 219 had no physician order and no self-medication assessment done. During a concurrent interview and record review on [DATE] at 2:36 p.m. with ADON, Resident 58's MR, was reviewed. The MR indicated, Resident 58 had no self-medication assessment done and had no physician order to keep medication at bedside. ADON stated Resident 58 needed a physician order to keep medication at bedside. ADON stated Resident 58 had no physician order and no self-medication assessment done. During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated February 2023, the P&P indicated, The facility stores all medications and biologicals [class of medicine made from living organisms] in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. 2. During a concurrent observation and interview on [DATE] at 2:39 p.m. with LVN 3 on South-wing the following medications were stored in the medication cart: Insulin Lispro (used to lower blood sugar) opened on [DATE] and expired on [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Insulin Humalog (used to lower blood sugar) opened on [DATE] and expired on [DATE]. LVN 3 stated both insulins were expired. During a concurrent observation and interview on [DATE] at 3:11 p.m. with LVN 2 on West-wing at medication cart, the following medications were found: Insulin Lantus (lowers blood sugar) opened on [DATE] expired on [DATE]. Insulin Lispro opened on [DATE] and expired on [DATE]. Insulin Lispro opened on [DATE] and expired on [DATE]. LVN 2 stated all three insulins were expired. During a review of the facility's P&P titled, Medication Labeling and Storage, dated February 2023, the P&P indicated, Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 46958 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Resident Food and Dining Preferences for two of six sampled residents (Resident 58 and Resident 48) when: 1. One of six sampled residents (Resident 58) was not offered an alternative food item. 2. One of six sampled residents (Resident 48) tie preference for dinner was not honored. These failures had the potential for Resident 48 and Resident 58's nutritional needs to be not be met and the potential for weight loss. Findings: 1. During a concurrent interview and record review on 11/4/24 at 12:53 p.m. with Certified Nursing Assistant (CNA) 2, Resident 58's Meal Tray Ticket (MTT) dated 11/4/24 was reviewed. The MTT indicated, Dislikes: Asparagus. CNA 2 stated Resident 58 disliked asparagus and Resident 58's meal tray included asparagus. During a concurrent observation, interview, and record review on 11/4/24 at 1:15 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 58's MTT dated 11/4/24 was reviewed. The MTT indicated, Standing Orders: Garden Salad Garden Salad [sic] (2 Ranch Dressing, No Tomatoes). LVN 2 stated Resident 58 should have been served with green salad on the meal tray. Resident 58's meal tray did not include a green salad. 45654 2. During an interview on 11/5/24 at 11:37 a.m. with Family Member (FM) 1, FM 1 stated Resident 48 liked to have a late dinner. FM 1 stated she must keep Resident 48's meal tray warm or reheat tray in the microwave at 7 p.m. to 7:30 p.m. During an interview on 11/6/24 at 2:20 p.m. with CNA 4, CNA 4 stated if a resident did not want to eat dinner, the meal tray could be taken back to the kitchen or residents could get a sandwich for later. During an interview on 11/6/24 at 2:24 p.m. with Certified Dietary Manager (CDM), CDM stated if a resident likes to eat later, food preferences can be accommodated. During a review of the facility's P&P titled,Resident Food and Dining Preferences, dated January 2023, the P&P indicated, Updates preferences on admissions, annually, and/or as desired by resident. If the community offers a select menu, buffet or other program that provide food choices at each meal, individual choices at each meal or snack take precedence over food preferences on file. Individual food and dining preferences incorporating religious, cultural, ethnic, and portion sizes are obtained from residents and/or a resident representative(s) on a regular basis.

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	11/07/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45654 Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled, Water Management Program for 71 of 71 sampled resident's when the facility cooling tower (device that removes heat from water and used to cool a building) tested positive for Legionella (bacteria causing lung infection). This failure had the potential to spread a highly contagious, infectious bacteria to residents, visitors, and staff. Findings: During an interview on 11/6/24 at 9:30 a.m. with Safety Officer (SO), SO stated the cooler connected to the water tower tested positive for Legionella and the water treatment company treated the water. SO stated he got the report on October 16th and he notified the facility Administrator, Infection Preventionist (IP), and Director of Operations (DO). During an interview on 11/6/24 at 9:35 a.m. with Director of Nursing (DON), DON stated the staff had not been in-serviced on Legionella or legionella pneumonia. During an interview on 11/6/24 at 12:26 p.m. with Field Technician (FT), FT stated the facility was responsible for treating water sources and following facility policy. During a concurrent interview and record review on 11/7/24 at 8:21 a.m. with IP, Legionnaire Testing (LT) dated 10/17/24, was reviewed. The LT indicated The first report is the annual water treatment test, which indicated a small amount of Legionella in the cooling tower; however, testing confirmed that it was not present in the kitchen or the health center. Please note that the tower was sanitized on October 16, 2024. IP stated an internal email indicated the building was not affected. During a concurrent interview and record review on 11/7/24 at 9:03 a.m. with SO, Analysis Report prepared for [NAME] (AR) dated 9/16/24 was reviewed. The AR indicated the following: 9/17/24, Sample 1 Tower Legionella Analysis on water using STL 127, CFU/Milliliters (unit of measure counting viable microbial cells) 5600 9/17/24, Sample 2 Kitchen sink CFU/ Milliliter 4, and 9/17/24, Sample 3 East Wing Sink CFU/ Milliliter less than 1. SO stated the analysis report in the cooling tower showed a slightly above normal and the sink was at an acceptable range. During a review of the facility's policy and procedure (P&P) titled, Water Management dated July 2017, the P&P indicated, Reviewing medical and microbiology records. b. Actively identifying all new and recent residents with healthcare-associated pneumonia and testing them for Legionella using both culture of lower respiratory secretion and the Legionella urinary antigen test. c. Developing a line list of cases. h. Decontaminating environmental source(s). (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	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Health Facility	1401 New Stine Road Bakersfield, CA 93309

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Centers for Disease Control and Prevention, Developing a Water management Program to Reduce Legionella Growth & Spread in Building, dated 6/24/21, indicated Identifying & Investigating Legionnaires Disease Cases. Healthcare facilities are often uniquely positioned to identify and respond to cases of Legionnaires' disease. A healthcare facility's water management program to limit Legionella growth and spread should include the actions to take when a patient is diagnosed with Legionnaires' disease or environmental triggers occur. If you decide to conduct a full investigation of the source of an infection, key elements should be included, as noted on the next page. A full investigation following a diagnosis of Legionnaires' disease can help determine whether the infection was acquired in the facility or the community. Clinicians should test patients with healthcare-associated pneumonia (pneumonia with onset [greater or equal to] 48 hours after admission) for Legionnaires' disease. This is especially important among patients at increased risk for developing Legionnaires' disease, among patients with severe pneumonia (particularly those requiring intensive care), or if any of the following are identified in your facility: Other patients with healthcare-associated Legionnaires' disease diagnosed in the past 12 months. Positive environmental tests for Legionella in the past 2 months. Current changes in water quality that may lead to Legionella growth (e.g. , low residual disinfectant levels, temperatures permissive to Legionella growth, nearby construction, areas of stagnation) Other patients, besides those with healthcare-associated pneumonia, should also be tested for Legionnaires' disease. The preferred diagnostic tests for Legionnaires' disease are culture of lower respiratory secretions on selective media and the Legionella urinary antigen test.