

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER The Rehabilitation Center of Bakersfield		STREET ADDRESS, CITY, STATE, ZIP CODE 2211 Mount Vernon Avenue Bakersfield, CA 93306	

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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39763</p> <p>Based on interview and record review, the facility failed to ensure two of three sampled residents (Resident 1 and Resident 2) activity assessment were completed. This failure had the potential for Resident 1 and Resident 3's activity needs not being met.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, (AR) the AR indicated, Resident 1 was admitted on [DATE].</p> <p>During a review of Resident 1's care plan with the focus on activity involvement, initiated 1/16/23 and revised on 8/30/23. The care plan indicated, The [Resident 1] will express satisfaction with type of activities and level of activity involvement when asked through the review date.</p> <p>During a review of Resident 3's AR, the AR indicated, Resident 3 was admitted on [DATE].</p> <p>During a review of Resident 3's care plan with the focus on independent activities, initiated 12/20/21 and revised on 12/21/23. The care plan indicated, The [Resident 3] will demonstrate satisfaction with his ability to engage in preferred activities during his stay.</p> <p>During a concurrent interview and record review on 3/29/24 at 2:22 p.m. with Activities Director (AD), AD stated activities assessment are completed on admission, quarterly, and annual. AD reviewed Resident 1's medical record. AD confirmed Resident 1's Activities Evaluation (AE) dated 1/30/23 was the most recent. AD confirmed Resident 1 should have had an AE completed on 4/23, 7/23, 10/23, and 1/24. AD reviewed Resident 3's medical record and confirmed Resident 3's AE, dated 8/23/23 was the most recent. AD confirmed Resident 3 should have had an AE completed in 11/23 and 2/24.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Activity Assessment/Care Plan, revised 11/1/13, the P&P indicated, To assess each resident's preferences for customary routine and activity interests, and to develop an individualized Care Plan for each resident. Procedure I. The Director of Activities coordinates the completion of an Activity Assessment for each resident. II. The director of Activities or his or her designee will conduct an initial interview and written assessment for each resident. III. Upon completion of the Activity Assessment and the MDS, the Director of Activities or his or her designee will develop and implement an individualized Care Plan. C. Care Plans will be reviewed and revised, as necessary, at least quarterly or more often if change of condition occurs. IV. The Activity Assessment is maintained as part of the resident's medical record.</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
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