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 05/30/2024
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)
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** 39763 Based on observation, interview, and record review, the facility failed to ensure the environment was free of accident hazards when one of 22 sampled residents of (Resident 1) was allowed to smoke unsupervised with oxygen applied. This resulted in Resident 1 sustaining second degree burns (partial thickness burns involving the top two layers of the skin) to the right and left cheeks. Findings: During a review of Resident 1's Admission Record, (AR) the AR indicated, Resident 1 is an [AGE] year-old male, admitted on [DATE], with the following diagnoses: Dementia (is not a single disease, but a term for range of conditions that affect the brain's ability to think, remember, and function normally) with psychotic disturbances (refers to the mental state where person has trouble figuring out what is real, may have auditory, visual, hallucinations), bipolar disorder (mental illness characterized by extreme mood swings), schizophrenia (a serious mental disorder in which people interpret reality abnormally) and tobacco use. The AR indicated Resident 1 is his own responsible party. During a review of Resident 1 ' s care plan with the focus on [Resident 1] is a smoker, High risk for injury r/t [related to] smoking., initiated 2/23/22, the care plan included the following interventions: instruct resident about the facility policy on smoking: locations, times, safety concerns initiated 2/23/22, monitor oral hygiene initiated 2/23/22, and the [Resident 1] requires SUPERVISION while smoking initiated 5/22/23. During a review of Resident 1 ' s care plan with the focus on, [Resident 1] Safety Regarding Lighter Use, the resident is non-complainant [resistant] with the facility ' s policy and wants to keep a lighter and cigarette on him initiated 11/11/23, the care plan included the following interventions: discuss the consequences of fire hazards, including personal injury and community safety Initiated 11/11/23, document any incidents or near misses related to lighter use and adjust the care plan accordingly initiated 11/11/23, educate the resident on fire safety and the specific risks of carrying a lighter initiated 11/11/23, and provide alternative coping strategies if the lighter is used for non-smoking purposes . initiated 11/11/23. During a review of Resident 1 ' s Order Details (OD) dated 3/23/24, the OD indicated, Oxygen @ [at] 3L [liters-unit of measure]/ [per] min[minute]Via Nasal Cannula [thin plastic tube used to deliver oxygen to the nostrils] to keep O2 [oxygen] Sat [saturations- how well the lungs are working] at/[or]above 93% [normal range 95%-100%] DX [diagnosis] SOB [shortness of breath] every shift. (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: 555256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Bakersfield	2211 Mount Vernon Avenue Bakersfield, CA 93306

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Smoking Safety, (SS) evaluation dated 3/25/24, the SS indicated, Balance problems while sitting or standing. Follows the facility ' s policy on location and time of smoking . [Resident 1] has history of smoking (no documentation regarding Resident 1 ' s ability to hold, light, and extinguish cigarette or the type of supervision Resident 1 needed). During a review of Resident 1's Minimum Data Set, (MDS - an assessment tool) dated 3/30/24, the MDS indicated, Resident 1' s Brief Interview for Mental Status score (BIMS score - an assessment to determine a resident ' s cognitive [term for mental processes] ability) score of 11 (a score of 8 to 12 indicates moderately impaired cognition). During a review of Resident 1 ' s Medication Administration Record, (MAR) dated 4/1/24 to 4/30/24, the MAR indicated Resident 1 received Oxygen @ 3L/min Via Nasal Cannula to keep O2 Sat at/above 93% DX SOB every shift -Start Date- 3/23/24 2300 . [required to check each shift, not documented each time oxygen is applied] During a review of Resident 1 ' s Progress Notes, (PN) dated 4/24/24 at 11:15 a.m., the PN indicated, [Resident 1] was found [sic] burns to the face while outside in the smoking area. During a review of the SBAR Communication Form [Method of documenting the condition of a patient to include Situation, Background, Assessment, Recommendation] dated 4/24/24 the SBAR Communication Form indicated, on 4/24/24 the resident sustained a skin wound or ulcer (open sore). The SBAR Communication Form indicated the resident sustained burns to the face and under the section titled Pain Evaluation, the documentation indicated the resident is experiencing pain due to Burns to face. During a review of Resident 1 ' s Weekly Skin/Wound Assessment, (WSWA) dated 4/24/24 at 12:25 p.m., the WSWA indicated Resident 1 sustained burns to the following areas: right cheek had popped blisters measuring 3.5 centimeters (cm - unit of measurement) in length and 2 cm in width; left cheek had a popped blister measuring 1.5 cm in length and 1.5 cm in width. The WSWA indicated, [Resident 1] has dark colored facial hair from soot/smoke to mustache, beard, right eyebrow, and eyelashes. During a concurrent observation and interview on 4/26/24 at 10:26 a.m. with Resident 1, in Resident 1 ' s room, Resident 1 was lying in bed. Resident 1 ' s face had circular redness with white colored substance noted on the right cheek approximately the size of a soda can, the skin under Resident 1 ' s nose was black (possible facial hair) with the white substance over the top of the skin, the left cheek had a quarter sized patch of red skin with white substance noted on top. Resident 1 stated, I started to light my cigarette and I just caught on fire [referring to the day of the incident on 4/24/24]. Resident 1 stated no one from the facility has talked to him about oxygen use on the smoking patio. Resident 1 stated I don ' t usually wear oxygen. Resident 1 stated he had a Certified Occupational Therapy Assistant (COTA 1) take him out to the smoking patio [on the day of the incident]. He stated, I told him [COTA 1] I want to go outside so I could smoke. Resident 1 stated when he went to the smoking patio there were no staff members present only other residents. Resident 1 stated occasionally there was a staff member on the smoking patio but usually it is only residents. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Rehabilitation Center of Bakersfield		STREET ADDRESS, CITY, STATE, ZIP CODE 2211 Mount Vernon Avenue Bakersfield, CA 93306	

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/26/24 at 10:48 a.m. with Certified Nursing Assistant (CNA 1), CNA I stated she has been assigned to care for Resident 1 and is familiar with his care needs. CNA 1 stated Resident 1 smokes independently and does not require assistance with holding or lighting his cigarette, she stated Resident 1 keeps his cigarettes and lighter in his room. CNA 1 stated he stores his cigarettes and lighter in his nightstand, and has found lighters in his closet. CNA 1 stated she has taken the resident out to the smoking patio area in the past. CNA 1 stated, when she takes the resident out to the smoking patio to smoke, If I don ' t see anyone [staff member on the smoking patio] I will just wait there with him. During an interview on 4/26/24 at 1:37 p.m. with Director of Nursing (DON), DON stated Central Supply (CS) was supposed to go to the smoking patio at 10 a.m. DON confirmed CS did not go to the smoking patio on 4/24/24. DON stated there was no staff on the smoking patio when Resident 1 sustained burns to the face. During a review of Resident 2' s MDS dated [DATE], the MDS indicated, Resident 2's BIMS score was 15 (13 to 15 points indicates cognitive intactness). During an interview on 4/29/24 at 2:07 p.m. with Resident 2, Resident 2 stated she was out on the smoking patio on 4/24/24. Resident 2 stated when she went outside to the smoking patio Resident 1 was already in the middle of the courtyard. Resident 2 stated Resident 1 had his oxygen on. Resident 2 stated, I told him [Resident 1] you cannot be smoking with oxygen on [and] he said, ' No no [COTA 1] turned it off. ' Resident 2 stated she was going to check to make sure his oxygen tank was off and just as she was next to Resident 1, she saw Resident 1 ' s face go up in flames. Resident 2 stated she grabbed the nasal cannula and threw it on the ground and then patted Resident 1 ' s face to put the fire out. Resident 2 then stomped on the nasal canula because it was still on fire. During an interview on 4/29/24 at 3 p.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated she responded when COTA 2 came running in on the date of the incident. LVN 1 stated COTA 2 informed her residents need a nurse outside on the smoking patio. LVN 1 stated, I went running and looked around, I noticed [Resident 1 ' s] face was black, and [Resident 2] was calling me over, the nasal cannula was black, and on the ground, it was not on fire. During an interview on 4/29/24 at 3:08 p.m. with COTA 2, COTA 2 stated she was crossing through the outside courtyard going to activities department, when she heard Help Help. COTA 2 stated she only saw two residents on the smoking patio. COTA 2 stated she turned around and ran to get a nurse. COTA 2 stated she took LVN 1 to where the two residents were outside on the smoking patio. During a concurrent interview and record review on 4/29/24 at 3:23 p.m. with Director of Nursing (DON), DON reviewed Resident 1 ' s OD, dated 3/23/24. DON stated Resident 1 did have an order for oxygen dated 3/23/24. DON reviewed Resident 1 ' s care plan initiated on 2/23/23 with the focus on, [Resident 1] is a smoker. High risk for injury r/t smoking. DON confirmed no interventions for oxygen were developed prior to the Resident 1 smoking with oxygen on and sustaining burns to his face. DON confirmed one of Resident 1 ' s care plan interventions initiated on 5/22/23 indicated Resident 1 needed supervision while smoking. DON confirmed Resident 1 was smoking unsupervised with oxygen on when his face caught on fire resulting in burns to Resident 1 ' s face. DON stated Resident 1 ' s face was observed to be black in color but then the face developed blisters, DON described Resident 1 ' s burns as second-degree burn. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 5/30/24 12:18 p.m. with DON reviewed Resident 1 ' s care plan with the focus on, [Resident 1] Safety Regarding Lighter Use, the resident is non-complainant with the facility ' s policy and wants to keep a lighter and cigarette on him., initiated 11/11/23, the care plan included the following interventions: discuss the consequences of fire hazards, including personal injury and community safety initiated 11/11/23, document any incidents or near misses related to lighter use and adjust the care plan accordingly initiated 11/11/23, educate the resident on fire safety and the specific risks of carrying a lighter initiated 11/11/23, and provide alternative coping strategies if the lighter is used for non-smoking purposes . initiated 11/11/23. Requested the policy and procedure (P&P) regarding lighter use. DON stated the facility does not have a P&P for safe lighter storage. DON stated safe lighter storage now is a lock box, but prior to the incident the alert and oriented residents were allowed to keep their lighter and cigarettes. DON reviewed Resident 1's medical record and was unable to provide evidence the interdisciplinary team (IDT) developed an individualized plan of care for safe storage and use of smoking materials for Resident 1. DON was unable to provide evidence Resident 1 was educated regarding the risk of smoking and smoking safety measures. During a review of facility policy and procedure (P&P) titled, Resident Safety, revised 4/15/21, the P&P indicated, Purpose To provide a safe and hazard free environment Policy Resident will be evaluated on admission, quarterly and whenever there is a change in condition to identify circumstance that pose a risk for the safety and wellbeing of the Resident. Procedure I. During the comprehensive assessment period the interdisciplinary team (IDT) members will assess the Resident ' s safety (e.g., fall, smoking, .) as well as any other Resident specific safety risks II. During the quarterly care plan review, when there is a change in condition or if an accident or incident occurs that involves the Resident ' s safety, the Resident ' s risk will be reevaluated III. After a risk evaluation is completed, a Resident -centered care plan will be developed to mitigate safety risk factors IV. The IDT will establish a person -centered observation or monitoring system for the resident to address the identified risk factors identified. During a review of facility P&P titled, Smoking Residents, effective date 8/18/23, the P&P indicated, 2. Smoking by residents is allowed outside the facility in designated, marked smoking areas with the following safety measures readily available: . 4. Oxygen use is prohibited in smoking areas.6. Using the Resident Smoking Assessment, the Licensed Nurse will assess residents who express a desire to smoke, upon admission, quarterly, annually and upon significant change of condition, and present it to the Interdisciplinary Team (IDT)for review. 8. The IDT will develop an individualized plan of care for safe storage, use of smoking materials, assistance and/or required supervision, for residents who smoke. 9. The resident and/or Responsible Party will be educated regarding the risk of smoking and smoking safety measures recommended by the IDT. This document will be in the resident ' s clinical record.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. 39763 Based on observation, interview, and record review, the facility failed to ensure: 1. Seven of 26 sampled residents (Resident 1, Resident 7, Resident 10, Resident 19, Resident 21, Resident 22, and Resident 23) Smoking and Safety (SS) Evaluation identified Resident 1, Resident 7, Resident 10, Resident 19, Resident 21, Resident 22, and Resident 23 ' s ability to hold, light and extinguish a cigarette safely. 2. Ten of 26 sampled residents (Resident 5, Resident 7, Resident 8, Resident 13, Resident 15, Resident 16, Resident 18, Resident 23, Resident 25, and Resident 26) smoking care plans were complete. 3. Four of 26 sampled residents (Resident 5, Resident 16, Resident 23, and Resident 26) SS assessment and care plan for smoking supervision records were accurate. These failures had the potential to result in Resident 1, Resident 5, Resident 6, Resident 7, Resident 8, Resident 10, Resident 13, Resident 15, Resident 16, Resident 18, Resident 19, Resident 21, Resident 22, Resident 23, Resident 25, and Resident 26 experiencing burn injuries and fire, which may affect other residents. Findings: 1. During a review of Resident 1 ' sSS, dated 3/25/24, the SS indicated, Balance problems while sitting or standing. Follows the facility ' s policy on location and time of smoking . resident has history of smoking (no documentation regarding Resident 1 ' s ability to hold, light, and extinguish cigarette or the type of supervision Resident 1 needed). During a review of Resident 7 ' s SS, dated 4/24/24, the SS indicated, Follows the facility ' s policy on location and time of smoking (no documentation regarding Resident 7 ' s ability to hold, light, and extinguish cigarette or the type of supervision Resident 7 needed). During a review of Resident 10 ' s SS, dated 4/23/24, the SS indicated, Balance problems while sitting or standing. Follows the facility ' s policy on location and time of smoking . [Resident 10] daily smoker (no documentation regarding Resident 10 ' s ability to hold, light, and extinguish cigarette or the type of supervision Resident 10 needed). During a review of Resident 19 ' s SS, dated 4/4/24, the SS indicated, Used to smoke now on nicotine patch (no documentation regarding Resident 19 ' s ability to hold, light, and extinguish cigarette or the type of supervision Resident 19 needed). During a review of Resident 21 ' s SS, dated 4/26/24, the SS indicated, Follows the facility ' s policy on location and time of smoking . [Resident 21] is alert and oriented. Smoker and does not require supervision when smoking. (No documentation regarding Resident 21 ' s ability to hold, light, and extinguish cigarette). (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 22 ' s SS, dated 3/25/24, the SS indicated, Follows the facility ' s policy on location and time of smoking . resident 22 does smoke. per resident she has not smoked since she went to hospital. resident is alert and orientedx3 [sic] (no documentation regarding Resident 22 ' s ability to hold, light, and extinguish cigarette or the type of supervision Resident 22 needed). During a review of Resident 23 ' s SS, dated 4/24/24, the SS indicated, Balance problems while sitting or standing. Follows the facility ' s policy on location and time of smoking . Resident does not need supervision while smoking. Resident is alert oriented (no documentation regarding Resident 23 ' s ability to hold, light, and extinguish cigarette). During a concurrent interview and record review on 4/26/24 at 3:36 p.m. with Director of Nursing (DON), DON reviewed SS for Resident 1, Resident 7, Resident 10, Resident 19, Resident 21, Resident 22 and Resident 23. DON confirmed the SS did not indicate whether Resident 1, Resident 7, Resident 10, Resident 19, Resident 21, Resident 22 and Resident 23 were safe to smoke supervised or unsupervised. 2. During a review of Resident 5, Resident 6, Resident 8, Resident 13, Resident 15, Resident 16, Resident 18, Resident 23, Resident 25, and Resident 26's Care Plan (CP), the following were reviewed: a) Resident 5 ' s CP dated 11/22/22 indicated, Resident [5] is a smoker. The CP did not address cigarette and lighter storage. b) Resident 6 ' s CP dated 2/22/22 indicated, Resident [6] is a smoker. The CP did not address cigarette and lighter storage. c) Resident 8 ' s CP dated 12/15/23 indicated, Tobacco Use. The CP did not address cigarette and lighter storage. d) Resident 13 ' s CP dated 7/25/22 indicated, Resident [13] is a smoker. The CP did not address cigarette and lighter storage. e) Resident 15 ' s CP dated 5/22/23 indicated, The Resident [15] is a smoker. The CP did not address cigarette and lighter storage. f) Resident 16 ' s CP dated 4/24/24 indicated, The Resident [16] is a smoker. The CP did not address cigarette and lighter storage. g) During a review of Resident 18 ' s SS, dated 4/24/24, the SS indicated, Resident was an independent smoker.able to lit [sic] and extinguish cigarette without difficulty at this time. Resident 18 ' s CP dated 8/24/23 indicated, Tobacco Use. There was no documentation regarding Resident 18 ' s ability to hold, light, extinguish cigarette, no documentation regarding storage of cigarettes and lighter, or the type of supervision Resident 18 required. h) Resident 23 ' s CP dated 4/24/24 indicated, The resident [23] is a smoker. The CP did not address cigarette and lighter storage. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i) During a review of Resident 25 ' s SS, dated 4/24/24, the SS indicated, able to light and extinguish cigarettes. Resident 25 ' s CP dated 4/24/24 indicated, Tobacco Use. There was no documentation regarding Resident 25 ' s ability to hold, light, extinguish cigarette, no documentation regarding storage of cigarettes and lighter, or the type of supervision Resident 25 required. j) Resident 26 ' s CP dated 4/2/24 indicated, Tobacco Use. The CP did not address cigarette and lighter storage. During a concurrent interview and record review on 4/26/24 at 3:36 p.m. with DON, DON reviewed Resident 5, Resident 7, Resident 8, Resident 13, Resident 15, Resident 16, Resident 23, and Resident 26 ' s smoking care plans. DON confirmed Resident 5, Resident 7, Resident 8, Resident 13, Resident 15, Resident 16, Resident 23, and Resident 26 ' s smoking care plans did not address cigarette and lighter storage. DON reviewed Resident 18 and Resident 26 ' s SS and smoking care plans. DON confirmed no documentation regarding Resident 18 and Resident 25 ' s ability to hold, light, extinguish cigarette, storage of cigarettes and lighter, or the type of supervision required by Resident 18 and Resident 25. 3.a)During a review of Resident 5 ' s SS, dated 4/24/24, indicated, [Resident 5] is identified as independent smoker. with supervision. [Resident 5] safely lits [sic] and extinguish cigarette without difficulty at this time. During a review of Resident 5 ' s CP dated 11/22/22 indicated, [Resident 5] is a smoker. The CP indicated one of the interventions were, [Resident 5] needs help to lit [sic] the cigarette. The SS indicated Resident 5 safely lits and extinguish but the CP indicated Resident 5 needed help to lit the cigarette. During a review of Resident 16 ' s SS, dated 4/24/24, indicated, [Resident 16] was an independent smoker. able to lit and extinguish cigarette without difficulty at this time. During a review of Resident 16 ' s CP dated 4/24/24 indicated, [Resident 16] is a smoker. Resident 16 requires Supervision while smoking. Resident 16's SS and CP were inaccurate. During a review of Resident 23 ' s SS, dated 4/24/24 indicated, [Resident 23] does not need supervision while smoking. During a review of Resident 23 ' s CP dated 4/24/24 indicated, [Resident 23] is a smoker. The [Resident 23] needs supervision during smoking. Resident 23's SS and CP were inaccurate. During a review of Resident 26 ' s SS, dated 4/24/24, the SS indicated, [Resident 26] is an independent smoker.able to safely lit and extinguish cigarette without difficulty at this time. During a review of Resident 26 ' s CP dated 4/2/24 indicated, Tobacco Use. Supervised smoking with smoking apron. Resident 26's SS indicated independent smoker but the CP indicated needed supervision. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/26/24 at 3:36 p.m. with DON, DON reviewed Resident 5, Resident 16, Resident 23, and Resident 26 ' s SS and CP. DON stated the SS assessments do not match what is on the residents CP. During a review of facility P&P titled, Smoking Residents, effective date 8/18/23, the P&P indicated, 6. Using the Resident Smoking Assessment , the Licensed Nurse will assess residents who express a desire to smoke, upon admission, quarterly, annually and upon significant change of condition, and present it to the Interdisciplinary Team (IDT)for review. 8. The IDT will develop an individualized plan of care for safe storage, use of smoking materials, assistance and/or required supervision, for residents who smoke. This document will be in the resident ' s clinical record. During a review of facility P&P titled, Smoking Residents, dated 8/18/23, the P&P indicated, 2. Smoking by residents is allowed outside the facility in designated, marked smoking areas with the following safety measures readily available: . 4. Oxygen use is prohibited in smoking areas.6. Using the Resident Smoking Assessment, the Licensed Nurse will assess residents who express a desire to smoke, upon admission, quarterly, annually and upon significant change of condition, and present it to the Interdisciplinary Team (IDT)for review. 8. The IDT will develop an individualized plan of care for safe storage, use of smoking materials, assistance and/or required supervision, for residents who smoke. 9. The resident and/or Responsible Party will be educated regarding the risk of smoking and smoking safety measures recommended by the IDT. This document will be in the resident ' s clinical record.