

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 07/09/2024
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48901</p> <p>Based on observation, interview, and record review, the facility failed to implement their policy and procedure titled, Fall Management Program for one of three sampled residents (Resident 1) when Resident 1 did not have quarterly fall risk evaluations completed. This failure had the potential for Resident 1 to have fall incidents.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 7/9/24 at 11:45 a.m. in Resident 1's room, Resident 1 was lying in bed with a black brace on his right foot, and an orthopedic boot (foot support) under the right side of his bed. Resident 1 stated he went out on pass on Monday (6/24/24) and had a seizure (abnormal electrical activity in the brain that temporarily affects the consciousness, muscle control and behavior) while sitting on a bench at the park and fell off. Resident 1 stated he walked back to the facility and his pain was bad, I couldn't put my weight on it. Resident 1 stated the nurse at the facility assessed him and told him his foot was not swollen and gave him pain medication. Resident 1 stated he has episodes of seizures and take medications for it. Resident 1 stated he has been going out on pass on his own since February, ever week for about four hours each time. Resident 1 stated he has had seizures while out on pass before and had notified the facility. Resident 1 stated on Friday (6/28/24) he had an X-ray because of his continued pain and was told he had a fractured (broken bone) in the midfoot. Resident 1 stated he was transferred to the hospital for evaluation on the day of the X-ray.</p> <p>During a review of Resident 1's Admission Record [AR], dated 7/31/24, the AR indicated initial admitted [DATE].</p> <p>During a review of Resident 1's Fall Risk Evaluation [FRE], dated 4/1/23 at 6:52 a.m., the FRE indicated, Score: 6.0 [Low fall Risk].</p> <p>During a review of Resident 1's Minimum Data Set (MDS-a comprehensive, standardized assessment of each resident's functional capabilities and health needs) GG - Functional Abilities and Goals [MDS-GG], dated 5/24/24, the MDS-GG indicated a code of 88 (Not attempted due to medical condition or safety concerns) for able to walk at least 10 feet in a room, corridor, or similar space.</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
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/30/24 at 2:42 p.m. with Director of Nursing (DON), the quarterly fall risk evaluation was reviewed. DON stated the fall risk evaluations should be done quarterly or more frequently if there is a change of condition (COC). DON stated Resident 1's should have quarterly fall risk evaluations completed in between the dates of 4/1/23 (last fall risk evaluation) and 7/1/24 (recent fall risk evaluation). Resident 1's missing quarterly fall risk evaluations are January 2024 and April 2024.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Fall Management Program, dated 3/13/21, the P&P indicated, Purpose.To provide residents a safe environment that minimizes complications associated with falls.Policy.The Facility will implement a Fall Management Program that supports providing an environment free from fall hazards.Procedure.Fall Risk Evaluation.B. A licensed nurse will conduct a new fall risk evaluation quarterly, annually, upon identification of a significant change of condition, post fall and as needed.</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48901</p> <p>Based on observation, interview, and record review, the facility failed to implement their policy and procedure (P&P) titled, Out On Pass [OOP], for one of three sampled residents (Resident 1) when Resident 1's out on pass physician order was incomplete. This failure had the potential for Resident 1 to have negative health outcomes such as an unwitnessed seizure (abnormal electrical activity in the brain that temporarily affects the consciousness, muscle control and behavior), fall, and fracture (broken bone).</p> <p>Findings:</p> <p>During a review of Resident 1's Change of Condition (COC), dated 6/25/24 at 7:33 a.m., the COC indicated, Late entry for 6/24/24 At 4:30[p.m.] resident signed for OOP and came back at 8pm accompanied by CNA [certified nursing assistant-unidentified] in stable condition Assisted to the bathroom Resident claimed has heat stroke [severe heat illness] x [times] 2, seizure x3 and fall x2. Assessment done. No redness swelling noted. Resident was able to walk back to bed will continue to monitor. MD (Medical Doctor) aware, recommended neuro (neurological - affecting the nervous system) checks x 72hrs [hours].</p> <p>During a review of Resident 1's Admission Record [AR], dated 7/31/24, the AR indicated initial admitted [DATE].</p> <p>During an observation on 7/9/24 at 11:45 a.m. in Resident 1's room, Resident 1 was lying in bed with a black brace on his right foot, and an orthopedic boot (foot support) under the right side of his bed.</p> <p>During an interview on 7/9/24 at 11:45 a.m. with Resident 1, Resident 1 stated he went out on pass on Monday (6/24/24) and had a seizure while sitting on a bench at the park and fell off. Resident 1 stated he walked back to the facility and his pain was bad, I couldn't put my weight on it. Resident 1 stated the nurse at the facility assessed him and told him his foot was not swollen and gave him pain medication. Resident 1 stated he had episodes of seizures and take medications for it. Resident 1 stated he had been going out on pass on his own since February, ever week for about four hours each time. Resident 1 stated he had seizures while out on pass before and had notified the facility. Resident 1 stated on Friday (6/28/24) he had an X-ray because of his continued pain and was told he had a fractured (right 5th metatarsal-broken bone on the foot). Resident 1 stated he was transferred to the hospital for evaluation on the day of the X-ray.</p> <p>During a review of Resident 1's Care Plan (CP) titled, The resident has a seizure disorder, dated 6/20/23, the CP indicated, The resident will be free from injury from seizure activity through review date (9/24/24). Interventions. SEIZURE PRECAUTIONS: Do not leave resident alone during a seizure, Protect from injury.</p> <p>During a review of Resident 1's Radiology Results Report [RRR], dated 6/28/24 13:13 (1:13 p.m.), the RRR indicated, CONCLUSION: Fracture distal [site located away from a specific area] fifth metatarsal [right].</p> <p>(continued on next page)</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Face Sheet [FS], dated 7/31/24, the FS indicated, DIAGNOSIS INFORMATION.OTHER SEIZURES.MUSCLE WEAKNESS.</p> <p>During an interview on 7/17/24 at 1:41 p.m. with Licensed Vocational Nurse (LVN), LVN stated she was the AM shift nurse for Resident 1. LVN stated Resident 1 did not have a seizure that morning when Resident 1 went out on pass and returned back to facility with a fracture (6/24/24). LVN stated she would notify the doctor if residents were going out on pass and the doctor needs to okay it.</p> <p>During an interview on 7/30/24 at 1:30 p.m. with Registered Nurse (RN), RN stated on 6/24/24, Resident 1 had gone out on pass, and when he returned to the facility, Resident 1 told her that he had fallen at the park and it was hurting. RN stated she assessed his toe and there was no swelling and discoloration. RN stated he notified the doctor who told her to observe Resident 1. RN stated Resident 1 is alert and oriented and responsible for himself so he can go on his own on out on pass.</p> <p>During a review of Resident 1's Care Plan (CP) titled, The resident had an alleged fall while OOP (6/24) - The resident also stated he had a seizure, dated 6/24/24, the CP indicated Resident to be monitored for 72 hours per MD's order.</p> <p>During a review of Resident 1's Minimum Data Set (MDS-a comprehensive, standardized assessment of each resident's functional capabilities and health needs) GG - Functional Abilities and Goals [MDS-GG], the MDS-GG indicated a code of 88 (Not attempted due to medical condition or safety concerns) for able to walk at least 10 feet in a room, corridor, or similar space.</p> <p>During an interview on 8/8/24 at 1:36 p.m. with DON, DON stated their policy on out on pass indicated the resident physician should indicate the length of time the resident should be out on pass, and whether the resident could go out on pass on their own or needs to be accompanied by a responsible person while out on pass. DON stated he looked into Resident 1's physician progress notes, where the physician can write if the resident can go out on pass on his own or needs to be accompanied and the length of time to be out on pass, and nothing was mentioned. DON stated Resident 1's physician order for out on pass does not mention length of time or if he should be accompanied or able to go on his own. DON stated this facility's P&P (Out on Pass) was not followed.</p> <p>During a review of Resident 1's Order Details [OD], dated 5/8/24 at 8:32 a.m., the OD indicated, Resident may go out on pass.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Out On Pass, dated 1/11/16, the P&P indicated, Policy.It is the policy of the Facility to meet residents' physical and psychosocial needs when going out on pass. The Facility will make reasonable efforts to ensure the resident safety and uphold resident rights. Procedure.i. If the resident's Attending Physician.determines that the resident may participate in activities outside the Facility, the Attending Physician will write/give an order for a resident to go out pass on the physician order sheet. A. The Attending Physician's order should include whether the resident should be accompanied by a responsible person while on pass or may leave the facility unaccompanied. i. The physician should specify the length of time the resident may be on pass ii. In the absence of a specific order that indicates the resident may go out on pass unaccompanied, the resident must be accompanied by a responsible person. lii. If the resident is receiving skilled service, the resident may go out pass for a therapeutic purpose only. The therapeutic reason and benefit to the resident must be documented in the clinical record.</p>		