| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555256 | A. Building<br>B. Wing | 07/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Rehabilitation Center of Bakersfield | 2211 Mount Vernon Avenue<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39763<br><br>Based on observation, interview, and record review, the facility failed develop and implement a care plan (CP- provides direction on the type of nursing care the individual may need) for one of three sampled residents (Resident 1) identified as 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 a DTI (deep tissue injury- 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]) in left foot, a blister to right heel (back part of the foot below the ankle), and unstageable PI (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).<br><br>Findings:<br><br>During an observation on 5/16/24 at 10:30 a.m. outside of Resident 1's room, Resident 1 was observed lying on his bed. Resident 1 was on his right side facing the wall with a lightweight blanket draped across his body. Resident 1 had pillows elevating his legs with his heels floating above the bed.<br><br>(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 |
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| | | |

| 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 07/25/2024 |
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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a concurrent observation and interview on 5/16/24 at 1:03 p.m. with Certified Nursing Assistant (CNA 3), outside Resident 1's room, Resident 1 was noted on his right side facing the wall with a lightweight blanket draped across his body. Resident 1 had pillows elevating his legs with his heels floating above the bed. CNA 3 stated was assigned to Resident 1. CNA 3 stated Resident 1 was dependent with activities of daily living (ADL). CNA 3 stated Resident 1 had multiple sores (PI). There was no meal tray noted in Resident 1's room. CNA 3 confirmed Resident 1 did not have a meal tray in his room and Resident 1 was not fed lunch. CNA 3 stated the last time she checked Resident 1 was at 10 a.m. today. CNA 3 stated she was assigned to the dining room for meal service. CNA 3 stated No one covers (provides care or services: feeding, changing, or turning for Resident 1) while I'm on break or when I'm assigned in the dining room. CNA 3 confirmed Resident 1 was in the same position she left him in at 10 a.m. (3 hours) today.<br><br>During a review of Resident 1's Admission Record, (AR) the AR indicated, Resident 1 was admitted on [DATE], with diagnoses including hemiplegia (muscle weakness or partial paralysis [unable to move body] on one side of the body that can affect the arms, legs, and facial muscles]) and hemiparesis (one-sided muscle weakness) following cerebral infraction (occurs as a result of disrupted blood flow to the brain and you may become paralyzed on one side of the body, or lose control of certain muscles) affecting right dominant (ruling or governing) side, other symptoms and signs involving cognitive functions (such as attention, memory, and executive functions [reasoning, planning, problem solving, and multitasking]), following unspecified cerebrovascular disease (a variety of medical conditions that affect the blood vessels of the brain and the circulation [movement of blood] in the brain), unspecified severe protein calorie malnutrition (refers to a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), nutritional deficiency (occurs when the body is not getting enough nutrients such as vitamins and minerals) and need for assistance with personal care.<br><br>During a review of Resident 1' s quarterly Minimum Data Set, (MDS- an assessment tool) dated 2/13/24, the MDS indicated, Resident 1's BIMS (Brief Interview for Mental Status- an assessment of cognition [mental processes including perception, memory, and thought]) score was 4 (a score of 0-7 indicates resident has severely impaired cognition). The MDS indicated Resident 1 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) for eating, 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 bed), lying to sitting on side of bed (the ability to move from lying on the back to sitting on the side of the bed and with no back support), and chair/bed-to chair transfer (the ability to transfer to and from a bed to a chair or wheelchair).<br><br>During a review of Resident 1's Braden Scale for Predicting Pressure Ulcer Risk Evaluation, (Braden) dated 2/27/24, the Braden Scale indicated, Resident 1 scored 12 (score of 10-12 indicate high risk for developing a pressure injury).<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 1's Nutrition/Dietary Note, (NDN) dated 4/12/24, the NDN indicated Resident 1's current weight was a 125 pounds on 4/5/24 in comparison to 141 pounds on 3/3/24 (16 pounds and 11.3% weight loss in approximately one month). The NDN indicated, Significant weight loss at 1 mo (month) and 6 mo is unplanned and undesired.Diet: regular diet (general or normal diet), regular texture (all food textures and covers [NAME] that people with no chewing or swallowing issues eat), thin liquids (are most often used if you do not have a swallowing problem with liquids. Examples are water, milk, tea, coffee, and juice) . (Resident 1) continues with GT (gastrostomy tube (also called a G-tube) is a tube inserted through the belly that brings nutrition directly to the stomach) in place . This writer visited (Resident 1) this morning. (Resident 1) has a thin appearance and muscle wasting (loss of muscle mass) to bilateral calf muscles. (Resident 1) eats better at lunch and dinner, (sic) and is assisted with meals but eats slowly.Due to significant weight losses; (sic) recommended restart enteral feedings (tube feeding delivers liquid nutrition through a flexible tube that goes directly into the stomach) for nocturnal feedings (when the tube feeding is done overnight). Recommended Jevity 1.5 (is calorically dense, fiber-fortified therapeutic nutrition that provides complete, balanced nutrition for long- or short-term tube feeding) @ (at) 65 cc (cubic centimeters- unit of measure)/hr. (hour) x.(times) 12 hours. Goal: Enteral feeding/PO (by mouth) intakes to meet estimated nutritional needs; maintain adequate hydration status; improve skin integrity; no significant weight variance (changes in weight).<br><br>During a review of Resident 1's SBAR (situation, background, appearance, and review) Communication Form, (SBAR) dated 4/20/24, the SBAR indicated, Wound Nurse notified me Resident has a new DTI in left foot (4/20/24).<br><br>During a review of Resident 1's SBAR, dated 4/25/24, the SBAR indicated Resident 1 had a blister to right heel (4/25/24).<br><br>During a review of Resident 1's SBAR, dated 4/26/24, the SBAR indicated, (Resident 1) noted to have a 4. 2x3utd [sic] (unable to determine) pressure injury to coccyx today (4/26/24).<br><br>During a review of Resident 1's SBAR, dated 4/28/24, the SBAR indicated, (Resident1) continues to be on monitoring for unstageable pressure injury to the coccyx, and blister to left heel, (Resident 1) turned and repositioned every 2 hours as tolerated.<br><br>During a review of Resident 1's SBAR, dated 5/3/24, the SBAR indicated, Assessed by Wound Specialist with MD orders: left posterior (back) heel unstageable (4/28/24), left lateral (to the side of, or away from, the middle of the body) planter (the thick tissue on the bottom of the foot) foot DTI larger (4/20/24), Coccyx clarified to sacrococcyx (the fused sacrum [a triangular bone in the lower back] and coccyx)unstageable and larger (4/26/24), right heel clear fluid bister now DTI and larger (4/25/24) .<br><br>During a review of Resident 1's NDN, dated 5/12/24, the NDN indicated, (Resident 1's) WTS (weights): 116. 5# (pounds) (5/3/24) 127.8#(4/5/24) (sic), 141.4#(2/3/24) (sic), 144.6#(11/1/23) (sic) WT changes: 11.3#(8. 9%)loss (sic) x1 week, 8.5#(6.8%) (sic) loss x1 month, 25.1#(17.8%)lossx3 (sic) months, 28.1#(19.4%)loss (sic) x6 months . Skin: US (unstageable) to left posterior heel, Sacrococcyx. (Resident 1) was placed on nocturnal feedings & (and) has snacks bw (between) meals.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 5/30/24 at 12:44 p.m. with Director of Nursing (DON), The SBAR dated 4/20/24, 4/25/24, and 4/26/24, were reviewed. DON confirmed Resident 1 developed three PIs while in the facility's care. DON stated Resident 1 also had a significant weight loss. Resident 1's active care plans (care plans CNAs were able to view in point of care (POC= electronic charting system), was reviewed. There was no care plan developed and implemented for PI prevention. DON confirmed the findings and stated Resident 1 was sent out to the acute hospital (2/5/24) and when Resident 1 was sent out, the nurses deactivated Resident 1 ' s care plans. DON was informed Resident 1 had no lunch meal tray on 5/16/24. DON reviewed Resident 1's NDN dated 4/12/24 and 5/12/24, DON confirmed Resident 1 had orders to receive PO diet, snacks, and G-tube feedings. Resident 1's Documentation Survey Report, DSR dated 4/2024 and 5/2024, was reviewed and there was no documentation Resident 1 was provided 65 out 177 meals. DON confirmed the findings and stated Resident 1 should get a regular diet and should get three meals a day.<br><br>During a review of the facility's policy and procedure (P&P) titled, Pressure Injury Prevention, revised September 1, 2020, the P&P indicated, To provide interventions for Residents identified as high risk for developing pressure injuries Policy The licensed Nurse will develop a care plan that contains interventions for Residents who have risk factors for developing pressure injuries or for those Resident who have pressure injuries and at risk of developing additional pressure injuries.II. Regardless of the score, the Licensed Nurse will develop and individualized care plan for the Resident's risk factors in consultation with the following: .C. Registered Dietician .III. The nursing staff will implement interventions identified in the care plan which may include,(sic) but are not limited to the following: . B. Repositioning and turning C. Heel and elbow protectors . E. Off-loading pressure from heels . K. Monitoring food and fluid intake .VII. Licensed Nurses will document the effectiveness of the pressure injury prevention techniques in the Resident's medical record on a weekly basis A. Interventions that are not effective or that the resident refuses . C. The care plan will be initiated on admission and updated as necessary . |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>39763<br><br>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 2) received the prescribed nutrients. This failure had the potential for unmet care needs and weight loss.<br><br>Findings:<br><br>During a concurrent interview and record review on 7/25/24 at 3:45 p.m. with Director of Nursing (DON 2), DON 2 reviewed Resident 2's Order Details (OD) dated 5/2/24 and 5/17/24, the ODs indicated Resident 2 would receive a standard (regular) portion diet. The Nutrition/Dietary Note, (NDN) dated 5/2/24, was reviewed, the NDN indicated Resident 2 should receive a 4 oz pureed (blended) snack daily. Resident 2's NDN dated 5/2/24, was reviewed, the NDN indicated, Resident 2's diet was upgraded to pureed texture and Resident 2 was to receive G-tube (gastrostomy tube is a tube inserted through the belly that brings nutrition directly to the stomach) bolus feeding (way to give large doses of formula several times a day) twice daily between meals. Resident 2's Documentation Survey Report, (DSR) dated 5/2024, was reviewed. DON confirmed there was seven meals not documented as provided, and 13 snacks not documented as provided. DON 2 stated there was no evidence the Certified Nursing Assistants (CNAs) were providing meals and snacks to the resident.<br><br>Resident 2's Medication Administration Record, (MAR) dated 5/2024, was reviewed and DON confirmed the following:<br><br>Enteral Feeding Order at bedtime Jevity 1.5 (is calorically dense, fiber-fortified therapeutic nutrition that provides complete, balanced nutrition for long- or short-term tube feeding] (bolus via g-tube) . -Start Date- 5/17/24 2100 [9 p.m.]<br><br>5/17/24, there was no documentation the feeding was provided.<br><br>5/18/24, there was no documentation the feeding was provided.<br><br>5/19/24, there was no documentation the feeding was provided.<br><br>5/26/24, there was no documentation the feeding was provided.<br><br>4 oz Sugar Free House Supplement /Milk Shake two time a day -Start Day- 05/18/2024<br><br>5/18/24, there was no documentation the snack was provided.<br><br>5/19/24, there was no documentation the snack was provided.<br><br>DON 2 stated the expectation is documentation is done right then. DON 2 stated If it is not documented it is not done.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's policy and procedure (P&P) titled, Food and Fluid Percentage Documentation, revised 8/11/20, the P&P indicated, Policy To accurately document the food percentage and fluid intake at mealtimes Procedure I. The CNA will record the percentage of all food and fluid intake in the Resident's ADL (activities of daily living- bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating) Flowsheet after each meal .<br><br>During a review of the facility's P&P titled, Medication-Administration, revised 1/1/12, the P&P indicated, A. Medications and biological orders will be reviewed by a Licensed Nurse prior to administration. Holding Medications A. Whenever a medication is held for anu reason, the hour it was held must be initialed and circled in the Medication Administration Record (MAR) by the responsible Licensed Nurse. B. The licensed Nurse will document on the back of the MAR, noting the time and reason the medication was held. VIII. Refusing Medication A. If a resident is refusing to take medications, time of refusal must be circled in the Medication Administration Record (MAR) by the responsible Licensed Nurse who is passing meds and documentation will be entered on the back of the MAR stating the reason for the refusal. Nurse will notify M. D. and document in the medical record. IX. Documentation A. The time and dose of the drug or treatment administered to the patient will be recorded in the patient's individual medication record by the person who administered the drug or treatment. B. Recording will include the date, the time, and the dosage of the medication or type of the treatment. |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39763<br><br>Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) received the prescribed nutrition (three meals a day: breakfast, lunch, and dinner) to meet nutritional needs and maintain desirable weight. This failure resulted in a 24.5- pound weight loss and 17.3 percent (%) of body weight in two months for Resident 1.<br><br>Findings:<br><br>During a concurrent observation and interview on 5/16/24 at 1:03 p.m. with Certified Nursing Assistant (CNA) 3 outside Resident 1's room. CNA 3 stated she was assigned to Resident 1. There was no lunch meal tray noted in Resident 1's room. CNA 3 confirmed Resident 1 did not have a lunch meal tray in his room. CNA 3 confirmed Resident 1 did not have a meal tray in his room and Resident 1 was not fed lunch. CNA 3 stated she last checked Resident 1 at 10 a.m. today. CNA 3 stated she was assigned to the dining room for meal service and no one covers (provides care or services: feeding, changing, or turning for Resident 1) while I'm on break or when I'm assigned in the dining room.<br><br>During a review of Resident 1's Admission Record, (AR) the AR indicated, Resident 1 was admitted on [DATE], with diagnoses including hemiplegia (muscle weakness or partial paralysis [unable to move body] on one side of the body that can affect the arms, legs, and facial muscles]) and hemiparesis (one-sided muscle weakness) following cerebral infraction (occurs as a result of disrupted blood flow to the brain and you may become paralyzed on one side of the body, or lose control of certain muscles) affecting right dominant (ruling or governing) side, other symptoms and signs involving cognitive functions (such as attention, memory, and executive functions [reasoning, planning, problem solving, and multitasking]), following unspecified cerebrovascular disease (a variety of medical conditions that affect the blood vessels of the brain and the circulation [movement of blood] in the brain), unspecified severe protein calorie malnutrition (refers to a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), nutritional deficiency (occurs when the body is not getting enough nutrients such as vitamins and minerals) and need for assistance with personal care.<br><br>During a review of Resident 1' s quarterly Minimum Data Set, (MDS - an assessment tool) dated 2/13/24, the MDS indicated, Resident 1's BIMS (Brief Interview for Mental Status- an assessment of cognition [mental processes including perception, memory, and thought]) score was 4 (a score of 0-7 indicates resident has severely impaired cognition). The MDS indicated Resident 1 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) for eating, 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 bed), lying to sitting on side of bed (the ability to move from lying on the back to sitting on the side of the bed and with no back support), and chair/bed-to chair transfer (the ability to transfer to and from a bed to a chair or wheelchair).<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 1's care plan (CP- provides direction on the type of nursing care the individual may need) with the focus on nutritional problem or potential nutritional problem r/t [related to] low fluid/food intake, initiated 2/6/24, with the goal The (Resident 1) will maintain adequate nutritional status as evidenced by maintaining weight . no s/sx (signs and symptoms) of malnutrition (lack of proper nutrition), and [sic] consuming at least (70) % of all meals daily through review date. The CP indicated, Monitor/document/report PRN [as needed] any.Refusing to eat, . and Provide and serve diet as ordered. Monitor intake and record q [every] meals.<br><br>During a review of Resident 1's Long Term Care Evaluation, (LTCE) dated 3/31/24, the LTCE indicated, Resident 1 was taking nutrition and hydration orally (by mouth) and had no signs or symptoms of swallowing disorder.<br><br>During a review of Resident 1's CP with the focus on Consuming less food and fluids. Pushes staff away when assisted with meals. Gets agitated when directed against his will. , initiated 4/4/24, with the goal (Resident 1) will consume 50% of meals , initiated 4/14/24. The CP indicated, Do not rush the patient to eat. Take your time to assist patient to eat. , initiated 4/14/24, Encourage patient to eat at least 75% of meal served. , initiated 4/14/24, and monitor percentage of meals consumed , initiated 4/14/24.<br><br>During a review of Resident 1's Nutrition/Dietary Note, (NDN) dated 4/12/24, the NDN indicated, Resident 1's current weight was a 125 pounds on 4/5/24 in comparison to 141 pounds on 3/3/24 (16 pounds and 11.3% weight loss in approximately one month). The NDN indicated, Significant weight loss at 1 mo (month) and 6 mo is unplanned and undesired.Diet: regular diet (general or normal diet), regular texture (all food textures and covers food that people with no chewing or swallowing issues eat), thin liquids (are most often used if you do not have a swallowing problem with liquids. Examples are water, milk, tea, coffee, and juice) diet.pro (protein) + (plus) snacks TID (three times a day) Rt (Resident 1) continues with GT (gastrostomy tube [also called a G-tube] is a tube inserted through the belly that brings nutrition directly to the stomach) in place.This writer visited (Resident 1) this morning.(Resident 1) has a thin appearance and muscle wasting to bilateral calf muscles. (Resident 1) eats better at lunch and dinner, [sic] and is assisted with meals but eats slowly. Due to significant weight losses; [sic] recommended restart enteral feedings (tube feeding delivers liquid nutrition through a flexible tube that goes directly into the stomach) for nocturnal feedings (when the tube feeding is done overnight). Recommended Jevity 1.5 (is calorically dense, fiber-fortified therapeutic nutrition that provides complete, balanced nutrition for long- or short- term tube feeding) @ (at) 65 cc (cubic centimeters- unit of measure)/hr. (hour) x.(times) 12 hours.Goal: Enteral feeding/PO (by mouth) intakes to meet estimated nutritional needs; maintain adequate hydration status; improve skin integrity.<br><br>During a review of Resident 1's NDN, dated 5/12/24, the NDN indicated, (Resident 1's) WTS (weights): 116. 5# (pounds) (5/3/24) .Jevity 1.5 @ 65 cc/hr x 12 hours. Diet: Regular- standard portion diet, Regular texture, Regular/Thin consistency (includes all liquids and is considered non-restrictive) . (Resident 1) Noted w/ (with) continued sig. (significant) weight loss. (Resident 1) has a variable PO intake. (Resident 1) was placed on nocturnal feedings & (and) has snacks bw (between) meals.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 5/30/24 at 12:44 p.m. with Director of Nursing (DON), Resident 1's Order Details, (OD) dated 4/9/24, the OD indicated, Order Summary . diet Regular . DON reviewed Resident 1's OD dated 5/12/24, the OD indicated, Order Summary Fortified Diet (adding everyday foods which are high in calories and protein. This does not increase the volume but can significantly increase the calories, protein, and other nutrients) diet [sic] Regular texture, Regular/Thin consistency. DON stated Resident 1 should be provided three meals a day (PO- by mouth), snacks and nocturnal GT feedings (Jevity). Resident 1's Documentation Survey Report, DSR dated 4/24 and 5/24 indicated:<br><br>Resident 1's Task Nutrition- Amount Eaten for 4/24<br><br>4/10/24 at dinner, the DSR indicated, there was no documentation a meal was provided.<br><br>4/16/24 at lunch, the DSR indicated, there was no documentation a meal was provided.<br><br>4/17/24 at breakfast, the DSR indicated, there was no documentation a meal was provided.<br><br>4/17/24 at lunch, the DSR indicated, there was no documentation a meal was provided.<br><br>4/17/24 at dinner, the DSR indicated, there was no documentation a meal was provided.<br><br>4/18/24 at breakfast, the DSR indicated, there was no documentation a meal was provided.<br><br>4/18/24 at lunch, the DSR indicated, there was no documentation a meal was provided.<br><br>4/18/24 at dinner, the DSR indicated, there was no documentation a meal was provided.<br><br>4/19/24 at dinner, the DSR indicated, there was no documentation a meal was provided.<br><br>4/20/24 at dinner, the DSR indicated, there was no documentation a meal was provided.<br><br>4/21/24 at breakfast, the DSR indicated, there was no documentation a meal was provided.<br><br>4/21/24 at lunch, the DSR indicated, there was no documentation a meal was provided.<br><br>4/21/24 at dinner, the DSR indicated, there was no documentation a meal was provided.<br><br>4/22/24 at breakfast, the DSR indicated, there was no documentation a meal was provided.<br><br>4/22/24 at lunch, the DSR indicated, there was no documentation a meal was provided.<br><br>4/23/24 at breakfast, the DSR indicated, there was no documentation a meal was provided.<br><br>4/23/24 at lunch, the DSR indicated, there was no documentation a meal was provided.<br><br>4/24/24 at breakfast, the DSR indicated, there was no documentation a meal was provided.<br><br>4/24/24 at lunch, the DSR indicated there was no documentation a meal was provided.<br><br>(continued on next page) |

| 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 07/25/2024 |
| --- | --- | --- | --- |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
| --- | --- |
| The Rehabilitation Center of Bakersfield | 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.

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 4/24/24 at dinner, the DSR indicated, there was no documentation a meal was provided.<br><br>4/25/24 at breakfast, the DSR indicated, there was no documentation a meal was provided.<br><br>4/25/24 at lunch, the DSR indicated, there was no documentation a meal was provided.<br><br>4/25/24 at dinner, the DSR indicated, there was no documentation a meal was provided.<br><br>4/26/24 at breakfast, the DSR indicated, there was no documentation a meal was provided.<br><br>4/26/24 at lunch, the DSR indicated, there was no documentation a meal was provided.<br><br>4/26/24 at dinner, the DSR indicated, there was no documentation a meal was provided.<br><br>4/27/24 at breakfast, the DSR indicated, there was no documentation a meal was provided.<br><br>4/27/24 at lunch, the DSR indicated, there was no documentation a meal was provided.<br><br>4/27/24 at dinner, the DSR indicated, there was no documentation a meal was provided.<br><br>4/28/24 at breakfast, the DSR indicated, there was no documentation a meal was provided.<br><br>4/28/24 at lunch, the DSR indicated, there was no documentation a meal was provided.<br><br>4/29/24 at breakfast, the DSR indicated, there was no documentation a meal was provided.<br><br>4/29/24 at lunch, the DSR indicated, there was no documentation a meal was provided.<br><br>4/30/24 at breakfast, the DSR indicated, there was no documentation a meal was provided.<br><br>4/30/24 at lunch, the DSR indicated, there was no documentation a meal was provided.<br><br>4/30/24 at dinner, the DSR indicated, there was no documentation a meal was provided.<br><br>Resident 1's Task Nutrition- Amount Eaten for 5/24<br><br>5/1/24 at breakfast, the DSR indicated, there was no documentation a meal was provided.<br><br>5/1/24 at lunch, the DSR indicated, there was no documentation a meal was provided.<br><br>5/1/24 at dinner, the DSR indicated, there was no documentation a meal was provided.<br><br>5/2/24 at breakfast, the DSR indicated, there was no documentation a meal was provided.<br><br>5/2/24 at dinner, the DSR indicated, there was no documentation a meal was provided.<br><br>5/3/24 at breakfast, the DSR indicated, there was no documentation a meal was provided.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 5/30/24 at 12:44 p.m. with DON, DON confirmed the above findings and stated there was no documentation Resident 1 was provided 65 out 177 meals. Resident 1's Weights and Vital Summary for 3/24 thru 5/24, was reviewed and DON confirmed Resident 1's weight on 3/3/24 was 141 pounds. On 4/5/23, 125 pounds (16-pound weight loss and 11.3 percent of body weight in approximately one month). On 4/26/24, 127.8 pounds and on 5/3/24, 116.5 pounds (11.3- pound weight loss and 8.8 percent of body weight in one week). DON stated Resident 1 had a weight loss of 24.5 pounds (17.3 percent of body weight in two months) in two months.<br><br>During a review of the facility's policy and procedure (P&P) titled, Evaluation of Weight & Nutritional Status, revised April 21, 2022, the P&P indicated, To ensure that residents maintain acceptable parameters of nutritional status through evaluation of weight and diet. Policy I. The Facility will work to maintain an acceptable nutritional status for residents by: .B. Analyzing the assessment information to identify the medical conditions, causes and/or problems related to the resident's condition and needs. C. Defining and implementing interventions for maintaining, or [sic] improving nutritional status that are consistent with resident needs, goals, and recognized standards of practice.II. Definitions.B. Weight Loss -5 % &/or 5lb [pounds] in one month, 7.5 in three months, or 10% in six months, as well as unplanned weight.C. Avoidable - The resident did not maintain acceptable parameters of nutritional status and that the Facility did not do one or more of the following: .(2) Define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice; (3) Monitor and evaluate the impact of interventions; . |