

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 07/26/2024
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>37697</p> <p>Based on observation, interview, and record review, the facility failed to provide mail to one of three sampled residents (Resident 2) in a manner that would protect his privacy. This failure had the potential for someone to access Resident 2's mail without his consent and potential for violation of residents' rights.</p> <p>Findings:</p> <p>During a review of Resident 1's ADMISSION RECORD (AR), dated 7/24/24, the AR indicated, Resident 1 diagnosis including legal blindness, cardiomegaly (enlarged heart) and depression (a constant feeling of sadness and loss of interest).</p> <p>During a review of Resident 1's MDS (Minimum Data Set - an assessment tool) under section BIMS (Brief Interview for Mental Status - an assessment tool for cognition [cognition -the mental processes that take place in the brain, including thinking, attention, language, learning, memory and perception]), dated 6/18/24, the BIMS indicated, Resident 1 had a score of 15 (cognitively intact).</p> <p>During a concurrent observation and interview on 7/25/24 at 2:23 p.m. with Resident 1 in Resident 1's room, Resident 1 had a large clear plastic container full of multicolored beads in front of him on an overbed table. Resident 1 stated he is blind and used the beads to make bracelets and necklaces as an activity. Inside the large clear plastic container of multicolored beads was a letter addressed to Resident 2. Resident 1 stated he can feel the letter in the container, but he does not know who it belongs to since he is blind.</p> <p>During a concurrent observation and interview on 7/25/24 at 2:35 p.m. with Certified Nursing Assistant (CNA) 1 in Resident 1's room, CNA 1 observed Resident 1's large clear plastic container full of multicolored beads and verified there was a letter in there addressed to Resident 2. CNA 1 stated the large clear plastic container of beads belongs only to Resident 1 and is not used by any other residents as it is Resident 1's property. CNA 1 stated he did not know how Resident 2's mail got into the container, but it did not belong there. CNA 1 stated it could not have been placed there by Resident 2 because he had been out to the hospital for quite a few days (not able to identify exact date sent out).</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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/23/24 at 3:12 p.m. with Activities Assistant (AA), AA stated she handed out the mail to the residents today. AA stated she did not know how Resident 2's mail got placed with Resident 1 as Resident 1 did not have mail today and even if he did, she would have held it due to Resident 2 being in the hospital at this time. AA stated there is no facility process to check of who delivered the mail and who received mail.</p> <p>During an interview on 7/25/24 at 3:21 p.m. with Administrator, Administrator stated the facility does not have a process to track when a resident is handed mail and by what staff member. Administrator stated if a resident is not in the facility then the front office should hold their mail until they return.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Resident Rights - Mail, dated 1/1/12, the P&P indicated, Purpose . To ensure that residents have access to mail delivery. The Facility will not give mail to members of the resident's family unless the resident (or the representative/sponsor) authorizes the Facility to do so. Mail is delivered to the resident within twenty-four (24) hours of delivery to premises or to the Facility's post office box (including Saturday deliveries).</p>		

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.</p> <p>37697</p> <p>Based on observation, interview, and record review, the facility failed to provide fluids within reach for one of three sampled residents (Resident 1). This had the potential for Resident 1 to become dehydrated (a condition that occurs when the body loses too much water and other fluids that it needs to work normally).</p> <p>Findings:</p> <p>During a review of Resident 1's ADMISSION RECORD (AR), dated 7/24/24, the AR indicated, Resident 1 diagnosis including legal blindness, cardiomegaly (enlarged heart), chronic kidney disease (a long-term condition where the kidneys do not work as well as they should) and depression (a constant feeling of sadness and loss of interest).</p> <p>During a review of Resident 1's MDS under the section GG (an assessment of the level a care a resident requires), dated 6/18/24, the GG indicated, Resident 1 required set up assistance (assisting prior to and/or following an activity) from facility staff for eating/drinking.</p> <p>During a review of Resident 1's MDS (Minimum Data Set - an assessment tool) under section BIMS (Brief Interview for Mental Status - an assessment tool for cognition [cognition -the mental processes that take place in the brain, including thinking, attention, language, learning, memory and perception]), dated 6/18/24, the BIMS indicated, Resident 1 had a score of 15 (cognitively intact).</p> <p>During a concurrent observation and interview on 7/25/24 at 2:23 p.m. with Resident 1 in Resident 1's room, Resident 1 stated he is blind and required assistance from staff to set up his meals and drinks. Resident 1 stated, I'm thirsty is there anything to drink? Resident 1 did not have any fluids or pitcher of water within reach. On the left side of Resident 1's bed, out of reach, on top of a dresser, was a maroon-colored pitcher filled with water.</p> <p>During a concurrent observation and interview on 7/25/24 at 2:35 p.m. with Certified Nursing Assistant (CNA) 1 in Resident 1's room, CNA 1 verified the maroon-colored pitcher was Resident 1's water to drink and was out of Resident 1's reach. CNA 1 stated the pitcher of water should have been within Resident 1's reach. CNA 1 stated Resident 1 was not on any type of fluid restrictions, and he should have access to water/fluids at any time.</p> <p>During an interview on 7/25/24 at 3:21 p.m. with Administrator, Administrator stated resident's water/fluids should be within the resident's reach.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Hydration Program, dated 11/2015, the P&P indicated, Purpose . To ensure that residents with medical conditions that can contribute to shifts in water balance are identified . Certified Nursing Assistants (CNAs) will make sure that each of their assigned residents has a pitcher of fresh, cool water and a clean glass bedside, unless medically contraindicated.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>37697</p> <p>Based on observation, interview, and record review, the facility failed to provide a call light within reach for one of three sampled residents (Resident 1). This failure had the potential for the resident not to be able to call for assistance and result in negative consequences.</p> <p>Findings:</p> <p>During a review of Resident 1's ADMISSION RECORD (AR), dated 7/24/24, the AR indicated, Resident 1 diagnosis including legal blindness, cardiomegaly (enlarged heart) and depression (a constant feeling of sadness and loss of interest).</p> <p>During a review of Resident 1's MDS under the section GG (an assessment of the level a care a resident requires), dated 6/18/24, the GG indicated, Resident 1 was dependent on staff for toileting, bathing, oral hygiene, upper and lower body dressing, putting on/taking off footwear and personal hygiene.</p> <p>During a review of Resident 1's MDS (Minimum Data Set - an assessment tool) under section BIMS (Brief Interview for Mental Status - an assessment tool for cognition [cognition -the mental processes that take place in the brain, including thinking, attention, language, learning, memory and perception]), dated 6/18/24, the BIMS indicated, Resident 1 had a score of 15 (cognitively intact).</p> <p>During a concurrent observation and interview on 7/25/24 at 2:23 p.m. with Resident 1 in Resident 1's room, Resident 1 stated he is blind and required assistance from staff to eat, bathe, toilet and get into a wheelchair. Resident 1 stated he lets staff know he needs assistance by using the call light, but he cannot find it or feel it around him. Behind Resident 1's bed was Resident 1's call light clipped against the wall and hanging down toward the floor, the call light was out of Resident 1's reach.</p> <p>During a concurrent observation and interview on 7/25/24 at 2:35 p.m. with Certified Nursing Assistant (CNA) 1 in Resident 1's room, CNA 1 verified Resident 1's call light was not within reach. CNA 1 stated Resident 1's call light should be within reach but maybe staff (not identified) cleaned his room and left it out of his reach.</p> <p>During an interview on 7/25/24 at 3:21 p.m. with Administrator, Administrator stated resident's call lights should be within reach.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Communication - Call System, dated 1/1/12, the P&P indicated, Purpose . To provide a mechanism for residents to promptly communicate with Nursing Staff. Call cords will be placed within the resident's reach in the resident's room.</p>		