STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555256	A. Building B. Wing	08/06/2024

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37697 Based on observation, interview, and record review, the facility failed to provide psychotropic medications (medications used for mental health disorders) as ordered upon admission by a physician for one of three sampled residents (Resident 1). This resulted in Resident 1 verbalizing decreased ability dealing with stressors (anything that causes worry or emotional difficulty). Findings: During a review of Resident 1 ' s History and Physical (H&P), dated 6/16/24, the H&P indicated, Resident 1 diagnosis including generalized anxiety (a feeling of worry, unease and/or nervousness), depression (a common and serious medical illness that negatively affects how you feel, the way you think and how you act) and Post Traumatic Stress Disorder (PTSD - a disorder that develops in some people who have experienced a shocking, scary, or dangerous event). During a review of Resident 1 ' s Minimum Data Set (MDS- an assessment tool) under the section BIMS (Brief Interview for Mental Status - an assessment of cognition [mental processes including perception, memory, and thought]), dated 7/10/24, the BIMS indicated, Resident 1 had a score of 15 (cognition intact). During a concurrent observation and interview on 8/6/24 at 11:31 a.m. with Resident 1 in Resident 1 ' s room, Resident 1 stated she had been in the facility since 7/3/24. Resident 1 stated she has not gotten her medications for anxiety and depression since admission. Resident 1 stated she had been on antidepressant (medication for depression) for the last six years. Resident 1 stated she had major depression and PTSD since she was [AGE] years old. Resident 1 stated the depression and anxiety medication cannot not just suddenly be stopped. Resident 1 was observed teary eyed and stated, It ' s (not getting the anxiety and depression medication) affecting my anxiety and my ability to cope with stressors. During a review of Resident 1 ' s Preadmission Screening and Resident Review (PASRR - an assessment form to screen and evaluate a person for serious mental illness and/or intellectual disability), dated 6/22/24, the PASRR indicated, Resident 1 screened positive for serious mental illness and was on psychotropic medication which included Ecitalopram (medication for depression) and Lorazepam (medication for anxiety). (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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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s MEDICATION ADMINISTRATION RECORD (MAR), dated 7/24 and 8/24, the MAR indicated, Resident 1 was on monitoring every shift for the side effects of depression medication and anxiety medication. The MAR indicated Resident 1 was monitored for behaviors for the use of Ecitalopram (antidepressant) and Lorazepam (antianxiety). The MAR did not indicate Resident 1 was receiving the Ecitalopram or Lorazepam in both the month of 7/24 and 8/24. During a concurrent interview and record review on 8/6/24 at 3:20 p.m. with Director of Nursing (DON), Resident 1 ' s acute hospital Medications (Meds), dated 6/16/24 was reviewed. DON verified Resident 1 was on Ecitalopram 20 mg (milligram - a unit of measurement) daily and Lorazepam 0.5 mg every six hours as needed for anxiety at the acute hospital and was to continue the medication in the facility. DON stated the Lorazepam was discontinued by the facility physician, but the Ecitalopram was to be given as ordered. DON stated the Registered Nurses (RN) (not identified) in the facility failed to reconcile the acute hospitals medication list with the facility medication list causing the Ecitalopram orders to not be carried over and given to Resident 1. DON stated the morning nursing shifts are to reconcile the medications of new residents when they are admitted ensuring orders are correct. DON stated the facility IDT (interdisciplinary team - a team of various professionals that gather to discuss resident care) goes over resident psychotropic medications and consents in the mornings as well. DON verified Resident 1 had a consent for both Ecitalopram and Lorazepam to be given. DON stated he was not sure what happened with the facility IDT meeting about Resident 1 ' s psychotropic medications. DON stated a resident not receiving their psychotropic medications could have negative effects on their psychological well-being. DON stated Resident 1 not getting her Ecitalopram could affect her ability to be happy at the facility and her ability to deal with stressors. During a review of the facility ' s policy and procedure (P&P) titled, Medication - Administration, dated 1/1/12, the P&P indicated, Purpose . To ensure the accurate administration of medications for residents in the Facility. No medication will be used for any other patient other than the patient for whom it was prescribed. Nursing staff will keep in mind the ' seven rights ' of medication when administering medication. the seven ' rights ' of medication are . The right medication . The right amount . The right resident . During a review of the facility ' s policy and procedure (P&P) titled, Behavior Management, dated 1/16/20, the P&P indicated, Purpose . To ensure the facility provides the necessary behavioral healthcare and services to residents in accordance with their comprehensive assessment and person-centered plan of care. The facility will ensure that when a resident displays a mental disorder, psychosocial adjustment difficulties (e.g. crying, yelling, hitting, etc.) or has a history of trauma and/or post-traumatic stress disorder, they will receive appropriate treatment to address the problem or attain the highest practicable mental and psychosocial wellbeing. Efforts will be made by the Interdisciplinary Team (IDT) to implement non-pharmacological interventions to alleviate behavior symptoms before initiating any psychoactive medications. Drug interventions . If the attending physician determines that the resident requires psychoactive medication(s), they will follow the facilities informed consent policy (NP - 67 - Informed Consent) . The IDT will reassess the resident as needed to determine the effectiveness of the psychoactive medication .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 37697 Based on observation, interview, and record review, the facility failed to implement infection control practices for three of three sampled residents (Resident 1, Resident 2, and Resident 3) when: A. Medication given via inhalation (the process of breathing in medication) was shared amongst two residents (Resident 1 and Resident 2). B. Certified Nursing Assistant (CNA) 1 did not conduct hand hygiene per facility policy and procedure. These failures had the potential to spread infection to the residents, staff, and visitors. Findings: A. During a review of Resident 1 ' s MEDICATION ADMINISTRATION RECORD (MAR), dated 8/1/24, the MAR indicated, Resident 1 was on Albuterol Sulfate (medication that opens the air passages to the lungs to make breathing easier) 108 mcg (micrograms - a unit of measurement) two puffs via inhalation every six hours as needed for shortness of breath. During a review of Resident 1 ' s Minimum Data Set (MDS- an assessment tool) under the section BIMS (Brief Interview for Mental Status - an assessment of cognition [mental processes including perception, memory, and thought]), dated 7/10/24, the BIMS indicated, Resident 1 had a score of 15 (cognition intact). During an interview on 8/6/24 at 11:31 a.m. with Resident 1, Resident 1 stated she was on infection isolation (the separation and restricted movement of ill persons who have a contagious disease to prevent its transmission to others) because she had Covid (a highly contagious respiratory disease). Resident 1 stated yesterday (8/5/24) she was given her Albuterol inhaler for shortness of breath by a nurse (not identified), and it was in a yellow container with an orange cap, but today when she was given her Albuterol inhaler in a navy blue container with a green cap. Resident 1 stated she asked the nurse if she was given the wrong medication and was reassured it was her correct medication. During a review of Resident 1 ' s Progress Notes (PN), dated 8/2/24, the PN indicated, Resident 1 had tested positive for Covid infection and was placed on isolation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 8/6/24 at 12:56 p.m. with Licensed Vocational Nurse (LVN) 1 at the nursing station, LVN 1 stated she was the assigned nurse for Resident 1. LVN 1 went into the medication cart and pulled out all Albuterol medications for the residents in Resident 1 ' s area. LVN 1 pulled Resident 1 ' s Albuterol medication and verified it was in a navy-blue container with a green cap. The Albuterol container was not marked to indicate it belonged to Resident 1. The only label to indicate the Albuterol medication belonged to Resident 1 was on the box the Albuterol container came in with a date of 8/3/24. There was one other Albuterol medication observed and verified by LVN 1 in the same section as Resident 1. The other Albuterol container belonged to Resident 2. The Albuterol container was yellow and had an orange cap. There was no indication on the container the medication belonged to Resident 2 other than the box it came in with a date of 7/24/24. LVN 1 stated she gave Resident 1 her Albuterol medication at 8:45 a.m. today (8/6/24). LVN 1 stated Resident 1 had made a comment stating, She (Resident 1) said it (Albuterol medication) looked different and asked if she had another one and I said no this is the only one you have. LVN 1 verified Resident 1 had an active Covid infection and Resident 2 did not have a Covid infection. During a review of Resident 2 ' s MEDICATION ADMINISTRATION RECORD (MAR), dated 8/1/24, the MAR indicated, Resident 2 was on Albuterol Sulfate (medication that opens the air passages to the lungs to make breathing easier) 108 mcg (micrograms - a unit of measurement) one puff via inhalation every four hours as needed for COPD (Chronic Obstructive Pulmonary Disease - a lung disease that causes restricted airflow and breathing problems). During an interview on 8/6/24 at 3:20 p.m. with Director of Nursing (DON), DON stated pharmacy dispenses Albuterol inhalers with the resident information on the box but not on the container itself. DON stated if he was dispensing Albuterol medication, he would write the residents initials on the containers as to not mix them up with the wrong resident. DON stated the reason Resident 1 got two different colored Albuterol medications is that there was a mix up with another resident (Resident 2). DON stated Resident 1 and Resident 2 ' s Albuterol inhalers would need to be disposed of and new ones ordered since there was a cross contamination between both residents. DON stated the facility would need to come up with a system to identify individual inhalers. During a review of the facility ' s policy and procedure (P&P) titled, Medication - Administration, dated 1/1/12, the P&P indicated, Purpose . To ensure the accurate administration of medications for residents in the Facility. No medication will be used for any other patient other than the patient for whom it was prescribed. Nursing staff will keep in mind the ' seven rights ' of medication when administering medication. the seven ' rights ' of medication are . The right medication . The right amount . The right resident . B. During a concurrent observation and interview on 8/6/24 at 11:31 a.m. with Resident 1 in Resident 1 ' s room, Resident 1 was observed to be on infection isolation. Resident 1 stated she is on infection isolation because she had Covid. Resident 1 was observed to have a productive cough (a cough that produces mucous). During an observation on 8/6/24 at 12:14 p.m. in Resident 1 ' s and Resident 3 ' s hallway, CNA 1 was observed taking a water pitcher out of Resident 1 ' s room (Covid infection isolation room) with bare hands and walking to the facility kitchen. CNA 1 returned to Resident 1 ' s room and handed off the water pitcher to another CNA (unidentified) in the room. CNA 1 then proceeded to enter Resident 3 ' s room without washing her hands and prepare to feed Resident 3 her lunch. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3 ' s ADMISSION RECORD (AR), dated 8/19/24, the AR indicated, Resident 3 had a diagnosis of pneumonia (infection in the lungs), sepsis (infection of the blood), cognitive communication deficit (problem with communication caused by problems with language, memory, attention, and perception) and need for assistance with personal care. During an interview on 8/6/24 at 12:18 p.m. with CNA 1, CNA 1 stated she had taken Resident 1 ' s water pitcher to the kitchen and exchanged it for a new one. CNA 1 verified she had not washed her hands after handling Resident 1 ' s water pitcher and before entering Resident 3 ' s room to assist her with lunch. During an interview on 8/6/24 at 3:41 p.m. with DON, DON stated his expectation is for all staff to conduct hand hygiene (any action of hand cleansing) before and after entering resident rooms. During a review of the facility ' s policy and procedure (P&P) titled, Hand Hygiene, dated 9/1/2020, the P&P indicated, The Facility considers hand hygiene as the primary means to prevent the spread of infections. Hand hygiene means cleaning your hands by handwashing (washing hands with soap and water), antiseptic hand wash or antiseptic hand rub (i.e. alcohol-based hand rub (ABHR) including foam or gel). The following situations require appropriate hand hygiene . Before eating . After using the bathroom . After contact with blood, other body fluids, secretions, excretions, mucous membranes, non-intact skin, wound drainage and soiled dressing . Before and after food preparation . Before and after assisting a Resident with dining if direct contact with food is anticipated or occurs . Before donning and after doffing Personal Protective Equipment (PPE) . Immediately upon entering and exiting a resident room .