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	01/16/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of 29 sampled residents (Resident 9) was treated with dignity and respect, when Resident 9 used her call light to request assistance and did not receive staff assistance for approximately 45 minutes. This delay in response demonstrated a lack of respectful and dignified care and had the potential to negatively impact the resident's self-esteem. Resident 9 stated the delay in assistance was disrespectful.During a review of Resident 9's face sheet (a document containing demographic and admission information), it was noted that the resident was admitted to the facility on [DATE]. The documented diagnoses upon admission included Parkinsonism (a slowly progressive neurological disorder characterized by the gradual loss of dopamine-producing nerve cells in the brain) urinary tract infection, and a history of falls.During a review of Resident 9's Minimum Data Set (MDS-a resident assessment tool used to identify cognitive and physical functional status) assessment dated [DATE] it was noted that Resident 9's Brief Interview for Mental Status (BIMS) score was 11 out of 15. According to the BIMS scoring scale (0-6 severe cognitive impairment, 7-12 moderate cognitive impairment, 13-15 cognitively intact), this score indicates that Resident 9 had a moderate cognitive deficit.During an interview on 1/12/2026 at 3:07 p.m. with Resident 9, Resident 9 stated an incident that occurred on 1/11/2026 at approximately 7:10 p.m. Resident 9 further stated her urine leaked through her brief and clothing. She activated her call light to request staff assistance. According to the resident, she waited approximately 30 minutes with no response. Due to the lack of assistance, she independently propelled herself in her wheelchair to the nursing station to request help. Resident 9 stated after an additional 40 minutes, a staff member arrived and assisted her with changing her brief.During an interview on 1/14/2026 at 9:28 a.m. with Registered Nurse (RN) 1, RN 1 stated Resident 9 was frequently incontinent with bowel and bladder and staff should assist Resident 9 immediately upon request. During an interview on 1/14/2026 at 2:04 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 9 was incontinent of bowel and bladder. The CNA 2 stated that all call lights should be answered in a timely manner, generally within five minutes. CNA 2 further stated that it was unacceptable for a soiled brief to remain on a resident for approximately 45 minutes. During an interview on 1/14/2026 at 3:50 p.m. with License Vocational Nurse (LVN) 1, LVN 1 confirmed she worked the PM shift on 1/11/2026. LVN 1 stated while she was administering medications, Resident 9 approached her in the hallway in her wheelchair and requested assistance with changing her soiled brief. LVN 1 stated that she informed Resident 9 that CNA 1 was on a scheduled break and Resident 9 needed to continue to wait. During an interview on 1/14/2026 at 4 p.m. with CNA 1, CNA 1 confirmed she worked the PM shift on 1/11/2026 and was assigned to provide care to Resident 9. CNA 1 stated that at approximately 8:35 p.m., LVN 1 approached her and requested that she assist Resident 9. CNA 1 stated that LVN 1 reported Resident 9 was seated in her wheelchair, appeared upset, and stated that her call light had been activated for approximately 30 to 35 minutes. CNA 1 further stated that upon entering Resident 9's room, the resident was yelling at her and stated her call light had been on for an extended period. During an interview on 1/15/2026 at 8:44 a.m. with Resident 9, Resident 9 stated the delay in assistance was disrespectful. During a review of the facility policy and procedure (P&P) titled, Call System, date 8/24/2024, the P&P indicated, . Facility Staff will answer call alerts promptly and in a courteous manner.During a review of the facility's P&P titled, Resident Rights-Quality of Life, date January 2017, the P&P indicated, To ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure the residents' disposable care equipment (emesis basin, urinal, and urine collection containers) was maintained in a clean, sanitary and safe manner. The disposable care equipment's were found unlabeled, undated and uncovered in multiple residents' bathroom and at bedside. This deficient practice had the potential to expose residents to cross contamination and risk for infection.Findings:During initial rounds on 1/12/2026 at 2:50 p.m. to 2:54 pm, the following were observed:Bathroom in room [ROOM NUMBER]- there was an unlabeled urinal hanging on the safety rail and one unlabeled plastic bottle of body wash. There were two female residents housed in the room [ROOM NUMBER]. Bathroom in room [ROOM NUMBER]- there was an uncovered, unlabeled urine collection container found on the floor. There were two female residents housed in room [ROOM NUMBER]. Bathroom in room [ROOM NUMBER]- there was one unlabeled and undated emesis basin containing one toothbrush with a dried whitish substance covering the bristles and one unlabeled half-filled bottle of body wash.room [ROOM NUMBER] A- there was one unlabeled urinal hanging on the bedrail. Bathroom in 314- there was two unlabeled emesis basins containing one toothbrush each basin with a dried whitish substance covering the bristlesBathroom in 316 B- there was one unlabeled emesis basin containing one toothbrush with a dried whitish substance covering the bristles.During an interview 1/13/2026 8:53 a.m. with Certified Nursing Assistant 6 (CNA), CNA 6, stated that all disposable care equipment (emesis basin, urinals, and urine collection containers) should not be stored on the floor and they should be covered with clear plastic bag, labeled and dated. During an interview on 1/13/2026 at 8:57 a.m. with CNA 7, CNA 7 stated that the disposable care equipment such as basins, urinals and emesis basin are to be changed on a weekly basis. During an interview on 1/14/2026 9:24 a.m. with Infection Preventionist 1 (IP), IP 1 stated that these disposable items should be stored in a plastic bag labeled with their name and room number when not in use and it should be disposed of when soiled. During an interview on 1/14/2026 at 9:31 a.m. with IP 2, IP 2 stated that her function was to oversee infection control and CNAs were expected to change the disposable equipment when it is soiled, and if the urinal lid was missing. IP 2 confirmed that all disposable equipment should be labeled with their name before use, it should be stored in a clean plastic bag and stored at their bedside. The urinals should have a lid and it could be hung in their rails for use. During an interview on 1/14/2026 at 9 a.m. with the Director of Nursing (DON), DON stated the facility had no policy on the care and disposal of residents' bedside care equipment.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on an interview and record review, the facility failed to inform the Office of the State Long-Term Ombudsman (SLTO - independent advocate for residents in nursing homes) when one of three sampled residents (Resident 159) was transferred urgently to the general acute care hospital (GACH) and subsequently discharged from the GACH to an assisted living. This failure had the potential for Resident 159 to not receive the proper oversite, protection, and advocacy of the Office of the State Long-Term Ombudsman regarding continuity of care for future medical needs.During a review of Resident 159's admission Record (AR), dated 1/15/2026, the AR indicated that Resident 159 was admitted on [DATE] for management of an infection requiring intravenous (IV - medication administered directly into a vein) infusion of an antibiotic (medication used to treat infection).During a review of Resident 159's Order Summary Report (OSR), dated 10/19/2025, the OSR indicated that Resident 159 started IV antibiotic infusion on 10/20/2025 and was to continue until 11/2/2025.During a review of Resident 159's Physician Order, (PO) dated 10/26/2025, the PO indicated for Resident 159 to be sent urgently to a higher level of care for further evaluation of AMS (altered mental status) with a 7-day bed hold.During a review of Resident 159's eINTERACT Transfer Form V5, dated 10/25/2025, the transfer form had no indication of ombudsman notification.During an interview on 1/15/2026 at 11:59 a.m. with the case manager (CM) 1, the CM1 indicated that it was her responsibility to notify the ombudsman of Resident 159's transfer to the hospital as soon as possible when urgently transferred. CM1 verified this was not done.During an interview on 1/15/2026 at 11:59 a.m. with the Social Services Director (SSD), the SSD indicated that it was her responsibility to track transfers and that Resident 159's transfer was not on her internal tracking list. The SSD verified that Resident 159 did get admitted to the acute care hospital and did not return to the facility. The SSD verified the ombudsman was not notified.During a review of the facility's policy and procedure titled, Notice of Transfer / Discharge (NTD), dated 10/2017, the NTD indicated that, the State Long Term Ombudsman . when a resident's urgent medical needs require immediate transfer . be provided notice as soon as practicable.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) for one resident (Resident 13) accurately reflected her clinical status. This failure resulted in the transmission of inaccurate data to the Centers for Medicare and Medicaid Services (CMS) for Resident 13. During a review of Resident 13's undated admission Record , it indicated Resident 13 was admitted to the facility on [DATE] with a diagnosis that included: Hypertensive and chronic kidney disease with heart failure and stage 5 chronic disease, or end stage renal disease (high blood pressure has significantly damaged the kidneys and heart, leading to kidney failure (Stage 5/ESRD), requiring dialysis or transplant, and often accompanied by heart failure), and dependence on renal dialysis.During a concurrent interview and record review on 1/14/2026 at 10:10 a.m. with MDS Coordinator (MDSC), Resident 13's MDS Section O: J1- Special treatments, dated 3/19/2025 was reviewed. The MDS Section O: J1 indicated Resident 13 was not on dialysis. MDSC stated Resident 13 was admitted on [DATE], was already on dialysis, and there was a discrepancy on the MDS entry, the data was not accurately entered for the annual MDS dated [DATE]. During a review of Resident 13's Order Summary Report dated 3/5/2025, it indicated, Resident has dialysis M, W, F {Monday, Wednesday, Friday} for end stage renal disease at {Name of dialysis Center}. Chair time is at 4:30 a.m.p/u {pick up} time at 4 a.m. During a follow up interview on 1/15/2026 at 4 p.m. with MDSC stated, We don't have a policy and procedure on data entry, per our DON (Director of Nursing) and consultant, we follow RAI (Resident Assessment Instrument).

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure baseline comprehensive, person-centered care plans were developed and implemented for one of 29 sampled residents (Resident 44) when:1. Resident 44 did not have a care plan to address an identified need for oral care.2. Resident 44 did not have a care plan to address enteral feeding (getting nutrition through the stomach) need within 48 hours of admission.These failures resulted in a lack of guidance for staff for the provision of necessary care and placed Resident 44 at risk of inadequate nutrition, infection, decline, and comfort.Findings:1.During a review of Resident 44's Face Sheet (demographics), Resident 44 was readmitted to the facility on [DATE] with diagnoses to include dysphagia (difficulty swallowing), gastrostomy status (surgical opening in the stomach to receive nutrients and fluids via a tube), and type 2 diabetes mellitus (chronic condition when the body doesn't produce or use sugar effectively).During a concurrent observation and interview on 1/12/2026 at 3:03 p.m. with Resident 44 in his room, Resident 44's lips were severely cracked with flaking skin, and his tongue was red, cracked and covered with thick yellow scales. Resident 44 stated his lips and tongue were hurting and described the pain as a burning feeling. Resident 44 further stated staff were not consistent with providing daily oral care and he was unable to do it by himself.During a concurrent interview and record review on 1/15/2026 at 1:40 p.m. with the Director of Nursing (DON), Resident 44's Physician Orders (PO) dated 1/8/2026, and Care Plans were reviewed. The PO indicated oral care was to be completed every shift (three times a day) and there was no care plan for oral care. The DON stated Resident 44 should have a care plan for oral care.During a review of the facility's policy and procedures (P&P) titled, Person-Centered Care Planning, dated 5/22/2025, the P&P indicated, The baseline care plan will be developed and implemented, using the necessary combination of problem specific care plans to promote continuity of care and communication among facility staff. within 48 hours of the resident's admission. It will include, at minimum, the following information necessary on each care plan to properly care for a resident: initial goals based on the admission orders, physician orders.2. During a concurrent observation and interview on 1/12/2026 at 3:03 p.m. with Resident 44 in his room, there was a kangaroo pump (machine to deliver enteral feedings) next to Resident 44's bed, actively infusing [brand of nutrients] 1.5 calories at 50 mL an hour. Resident 44 stated he was previously hospitalized and lost the ability to swallow so he elected for a tube to be inserted in his stomach to receive nutrition.During a review of Resident 44's Physician Orders (PO), dated 1/8/2026, the PO indicated to administer [brand of nutrients] 1.5 calories at 50 mL an hour for 20 hours a day. During a concurrent interview and record review on 1/15/2026 at 1:45 p.m. with the DON, Resident 44's care plans were reviewed. The DON stated Resident 44 should have had a care plan completed within 48 hours of admission (by 1/10/2026) to include enteral feeding. The care plan for enteral feeding was not completed until 1/13/2026, five days after admission.During a review of the facility's policy and procedures (P&P) titled, Person-Centered Care Planning, dated 5/22/2025, the P&P indicated, The baseline care plan will be developed and implemented, using the necessary combination of problem specific care plans to promote continuity of care and communication among facility staff. within 48 hours of the resident's admission. It will include, at minimum, the following information necessary on each care plan to properly care for a resident: initial goals based on the admission orders, physician orders, dietary orders.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services for two of 29 sampled residents (Resident 44 and Resident 152), when:1. Resident 44 did not receive the necessary assistance with oral hygiene in accordance with the residents' assessed needs for seven days. This failure resulted in Resident 44 suffering unnecessary oral discomfort.2. Resident 152 did not receive physical therapy services necessary to maintain or improve functional abilities for two weeks. This failure had the potential to result in decline in mobility.Findings:1. During a review of Resident 44's Face Sheet (demographics), Resident 44 was readmitted to the facility on [DATE] with diagnoses to include dysphagia (difficulty swallowing), gastrostomy status (surgical opening in the stomach to receive nutrients and fluids via a tube), and type 2 diabetes mellitus (chronic condition when the body doesn't produce or use sugar effectively).During a concurrent observation and interview on 1/12/2026 at 3:03 p.m. with Resident 44 in his room, Resident 44's lips were severely cracked with flaking skin, and his tongue was red, cracked and covered with thick yellow scales. Resident 44 stated his lips and tongue were hurting and described the pain as a burning feeling. Resident 44 further stated staff were not consistent with providing daily oral care and he was unable to do it by himself.During an interview on 1/12/2026 at 3:27 p.m. with Certified Nursing Assistant (CNA) 8, CNA 8 confirmed Resident 44 needed maximum assistance with oral care, and stated oral care was completed once a day. CNA 8 further stated oral care was completed on whichever shift was able to complete the task.During a concurrent interview and record review on 1/15/2026 at 1:40 p.m. with the Director of Nursing, the following documents were reviewed:-Resident 44's Physician Orders (PO), dated 1/8/2026, the PO indicated oral care was to be provided three times a day (every shift).-Resident 44's Oral Hygiene, dated 1/8/2026 through 1/15/2026, the Oral Hygiene indicated Resident 44 received oral care once a day on 1/8/2026 and 1/10/2026, and twice a day on 1/9/2026 and 1/11/2026 through 1/15/2026.The DON stated Resident 44 should have received oral care three times a day in accordance with the physician order. During a review of Resident 44's admission Minimum Data Set (MDS-federally required clinical assessment tool) Section GG, dated 10/29/2025, the MDS indicated Resident 44 required moderate assistance for oral hygiene.During a review of facility's policy and procedures (P&P) titled, Oral Care, dated 1/1/2012, the P&P indicated, All residents receive appropriate oral care . It is the responsibility of each staff member within the nursing department is to ensure good oral care for each resident. Document oral care on any pertinent observations in the resident's medical record.2.During a review of Resident 152's Face Sheet, Resident 152 was admitted to the facility on [DATE], with diagnoses to include hemiplegia following cerebral infarction affecting left side (inability to move one side after stroke- loss of oxygen to the brain), muscle weakness, abnormalities of gait and mobility (unsteady, difficulty walking), muscle atrophy (shrinking/getting weaker). During a concurrent observation and interview on 1/13/2026 at 8:49 a.m. with Resident 152 in his room, Resident 152 was sitting in a wheelchair next to his bed. Resident 152 stated he was supposed to receive physical therapy 5 times a week but last week he only received physical therapy twice. Resident 152 further stated he wanted more physical therapy, so he could get strong enough to go home.During a concurrent interview and record review on 1/14/2026 at 9:42 a.m. with the Director of Rehabilitation (DOR), the following documents were reviewed:-Resident 152's Physician Order (PO), dated 12/29/2025, the PO indicated Resident 152 was to receive physical therapy five times a week for four weeks with a goal to ambulate 150 feet with a walker.-Resident 152's Physical Therapy Treatment Encounter Notes (PTTEN), dated 1/4/2026 through 1/14/2026, the PTTEN indicated Resident 152 only received physical therapy two times (1/4/2026 and 1/10/2026) in ten days.The DOR confirmed Resident 152 did not receive physical therapy in accordance with the physician order for the week of 1/4/2026 to 1/10/2026. The DOR stated there was not enough days left in the week of 1/11/2026 to 1/17/2026 to receive physical therapy five times a week. The DOR further stated he was not aware of Resident 152 not receiving physical therapy in accordance with the physician order and the assistant director of rehabilitation (ADOR) was responsible for scheduling.During an interview on 1/14/2026 at 2:54 p.m. with the ADOR, the ADOR stated she scheduled Resident 152 for physical therapy five times a week and was unaware he did not receive therapy.During a review of Resident 152's admission MDS Section GG, dated 11/17/2025, the MDS indicated Resident 152 needed maximum assistance to stand from a sitting position and Resident 152 was unable to ambulate 10 feet due to safety concerns During a review of Resident 152's Care Plan Report, dated 11/17/2025, the report indicated, at risk

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe administration of enteral nutrition (method of delivering liquid nutrition directly into the stomach or small intestine via a tube) for one of 29 sampled residents (Resident 44), when Resident 44 was observed lying flat while receiving nutrition via gastrostomy tube (surgical opening in the stomach to receive nutrients and fluids via a tube). This failure had the potential to result in aspiration (when food, liquid or saliva accidentally go down the airway) and pneumonia (lung infection).Findings:During a review of Resident 44's Face Sheet (demographics), Resident 44 was readmitted to the facility on [DATE] with diagnoses to include dysphagia (difficulty swallowing), gastrostomy status (surgical opening in the stomach to receive nutrients and fluids via a tube), and type 2 diabetes mellitus (chronic condition when the body doesn't produce or use sugar effectively).During a concurrent observation and interview on 1/12/2026 at 4:05 p.m. with Infection Preventionist (IP) 2, in Resident 44's room, Resident 44 was observed lying flat while receiving enteral feeding. IP 2 stated Resident 44 needed to be sitting up while receiving enteral feeding to prevent aspiration and infection.During an interview on 1/15/2026 at 1:45 p.m. with the Director of Nursing (DON), the DON stated no resident should ever lay flat while receiving enteral feeding for risk of aspiration.During a review of Resident 44's Physician Order (PO), dated 1/8/2026, the PO indicated to elevate the head of the bed 30-45 degrees while receiving enteral feedings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure safe handling of oxygen treatment was followed according to facility's policy and procedure to one resident (Resident 61). This failure had the potential to adversely affect Resident 61's respiratory health when her nasal cannula oxygen tubing was not replaced after 7 days of use. During a review of undated admission Record, it indicated Resident 61 was admitted to the facility on [DATE] with diagnosis that included COPD {Chronic Obstructive Pulmonary disease, asthma {a chronic lung condition where airways become inflamed, swollen, and narrow, producing excess mucus, making breathing difficult, dependence on supplemental oxygen. During a concurrent observation and interview on 1/12/2026 at 1:55 p.m. in room [ROOM NUMBER] Bed B, Resident 61 was observed receiving Oxygen treatment via a nasal cannula {NC} at 3 liters per minute. Resident 61 stated, They change the tubing but not sure how often. During a review of Order Summary Report for Resident 61, dated 5/29/26, it indicated Check O2 tubing date to ensure current for the week every night shift every Sunday. During a concurrent observation and interview on 1/12/26 at 2:28 p.m. with the Licensed Vocational Nurse (LVN 4), LVN 4 stated, the NC tubing was changed, weekly, dated and timed. LVN 4 also stated that Resident 61 was receiving O2 treatment for COPD, a progressive lung condition causing airflow obstruction, making breathing difficult. During an observation of the NC tubing for Resident 61 with LVN 4, the date on tubing indicated ;1/3/2026. LVN 4 stated, It should have been changed on 1/10/2026. During a review of Order Summary Report for Resident 61, dated 12/12/2024, it indicated Oxygen @ 3 LPM via nasal Cannula continuously for COPD. During a review of facility's policy and procedure (P&P) titled, P- N P94 Oxygen Therapy, dated October 30, 2025, the P&P indicated. a. Oxygen equipment shall be maintained as follows: i. The tubing and mask should be changed at least every 7 days and labeled with the date of change.

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The Rehabilitation Center of Bakersfield	2211 Mount Vernon Avenue Bakersfield, CA 93306

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure soup provided to a population of 146 residents was served at a palatable temperature. This failure had the potential to result in not respecting residents' preferences, promoting a positive dining experience, and weight loss due to food refusal.Findings:During an observation on 1/12/2026 at 5:02 p.m. in the dining hall, Certified Nursing Assistant (CNA) 5 served Resident 102 a cup of French onion soup. Resident 102 took a sip of the soup and shouted the soup was cold and she did not want the soup anymore.During an observation on 1/12/2026 at 5:05 p.m. in the dining hall, CNA 5 got a replacement cup of French onion soup and served again to Resident 102. Resident 102 took a sip of the soup and shouted, that is cold, I don't want it. Resident 102 pushed the cup of soup towards the other end of the dining table.During a concurrent observation and interview on 1/12/2026 at 5:07 p.m. with the Dietary Manager (DM) in the dining hall, the DM took Resident 102's second soup and checked the temperature, it read 116 degrees Fahrenheit. The DM stated the soup should have been hotter.During a concurrent observation and interview on 1/12/2026 at 5:27 p.m. with the DM in the kitchen, the DM went to the warmer and removed one of the cups of soup and checked the temperature. The temperature read 145 degrees Fahrenheit. The DM stated soups should be served at 170 degrees Fahrenheit.During a review of Recipe: French Onion Soup, dated 2025, the Recipe: French Onion Soup indicated, Serve on trayline at the recommended temperature of 170 F - 190 F .During a review of the facility's policy and procedures (P&P) titled, Food Temperatures, dated 10/10/2023, the P&P indicated, Acceptable serving temperatures. Soup. Preferable temperature 160 F - 175 F.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and record review, the facility failed to ensure food safety and sanitation guidelines were followed when:1. One can of roasted diced tomatoes was dented.2. Multiple food items were expired in dry storage room.3. Cauliflower and cabbage were expired in the walk-in refrigerator.4. Multiple food items were uncovered and undated in the walk-in freezer.5. One freezer containing partially melted ice cream was not maintained at the required temperature for frozen food storage.6. One cook did not wear a hair restraint while in the kitchen.7. C-wing's ice machine chute (the passage where ice travels down into a storage bin) was visibly dirty.These failures posed the risk of food borne illness in a medically fragile resident population of 146 facility residents who received food prepared in the kitchen and ice after the closing of the kitchen.Findings:1.During a concurrent observation and interview on 1/12/2026 at 1:13 p.m. with the Dietary Manager (DM) in the dry storage room, one can of roasted diced tomatoes was dented. The DM stated the can needed to be put in the disposal pile due to the risk of botulism (severe illness caused by a toxin that causes muscle weakness).During a review of the facility's policy and procedures (P&P) titled, Food Storage, dated 11/1/2014, the P&P indicated, Dented of bulging cans should be placed in separate area and returned for credit.2. During a concurrent observation and interview on 1/12/2026 at 1:17 p.m. with the Dietary Manager (DM) in the dry storage room, an opened gallon bottle of apple cider vinegar had a use by date of 8/6/2025. The DM stated it needed to be thrown away immediately.During a concurrent observation and interview on 1/12/2026 at 1:21 p.m. with the DM in the dry storage room, a clear plastic container labeled Classic Noodles with a use by date of 5/20/2025. The DM stated the noodles needed to be thrown away. During a concurrent observation and interview on 1/12/2026 at 1:24 p.m. with the DM in the dry storage room, a container of Mayo packets with a use by date of 11/16/2025 and a bottle of thickened orange juice with a use by date of 1/6/2026. The DM stated they needed to be thrown away.During a concurrent observation and interview on 1/12/2026 at 1:28 p.m. with the DM in the dry storage room, there was a container labeled Red onions with a use by date of 3/8/2025. Four of the six red onions had very dark decaying spots. The DM stated the red onions were unusable and needed to be thrown away.During a concurrent observation and interview on 1/12/2026 at 1:29 p.m. with the DM in the dry storage room, a bin labeled Red Potatoes were wilted and had many spuds growing with a use by date of 12/24/2025. The DM stated the potatoes needed to be thrown away.During a concurrent observation and interview on 1/12/2026 at 1:30 p.m. with the DM in the dry storage room, a container labeled Potatoes with a use by date of 12/24/2025 were wilted and had many spuds growing. The DM stated the potatoes needed to be thrown away.3. During a concurrent observation and interview on 1/12/2026 at 1:35 p.m. with the Dietary Manager (DM) in the walk-in refrigerator, two bags of cauliflower had a use by date of 1/10/2026. DM stated the cauliflower was expired and needed to be thrown away.During a concurrent observation and interview on 1/12/2026 at 1:36 p.m. with the DM in the walk-in refrigerator, two bags of cabbage had a use by date of 1/7/2026. DM stated the cabbage was expired and needed to be thrown away.4. During a concurrent observation and interview on 1/12/2026 at 1:37 p.m. with the Dietary Supervisor (DS) in the walk-in freezer, an opened, unlabeled and undated plastic bag contained an unknown pink meat with ice crystals. DS stated the meat was pork, and it should have been ensured it was closed with a label and date.During a concurrent observation and interview on 1/12/2026 at 1:39 p.m. with the DS in the walk-in freezer, a box of dinner rolls was uncovered and undated. The DS stated the dinner rolls should have been covered and dated.During a concurrent observation and interview on 1/12/2026 at 1:41 p.m. with the DS in the walk-in freezer, a box of chicken patties and a box of chicken and vegetable protein enchiladas were opened, uncovered and undated. The DS stated all foods needed to be covered, labeled and dated.5. During a concurrent observation and interview on 1/12/2026 at 1:44 p.m. with the Dietary Manager (DM) in the kitchen, a small white freezer had numerous vanilla ice cream cups that were not frozen, with no thermometer in the freezer. DM retrieved a thermometer and placed it in the freezer. At 1:55 p.m. (11 minutes later) DM checked the thermometer, and it read 11 degrees Fahrenheit. DM stated the freezer temperature should have been 0 degrees Fahrenheit or below and should not be used.During a review of the facility's policy and procedures (P&P) titled, Refrigerator/Freezer Temperature Records, dated 11/1/2014, the P&P indicated, The freezer temperature must be 0 F [Fahrenheit] or below. Corrective action should be taken to correct the temperature or the items should be moved to another storage area to maintain acceptable temperature.6. During a concurrent observation and interview on 1/12/2026 at 1:49 p.m. with the Dietary Manager (DM) in the

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure four of four outside dumpsters' lids were closed. This failure had the potential to attract pests and/or rodents that carried diseases and could result in food borne illness (a sickness caused by consuming food, or drinks contaminated with harmful substances) in a medically fragile population of 146 residents.Findings:During a concurrent observation and interview on 1/12/2026 at 1:57 p.m. with the Dietary Manager (DM) outside in the trash area, four of four dumpsters had overflowing trash with lids being unable to close, and multiple items of trash scattered around the dumpsters on the ground that contained food items. The DM confirmed that trash should not be laying on the ground and the lids should be covering all trash in the dumpsters.During an interview on 1/14/2026 at 2:03 p.m. with the Registered Dietician (RD), the RD stated she oversees the kitchen and lids to the dumpsters should be fully closed, to keep rodents out.During a review of the U.S [United States] Food and Drug Administration's (FDA) Food Code, dated 2022, the FDA Food Code indicated in Section 5-501.15 Outside Receptacles, (A) Receptacles and waste handling units for REFUSE, recyclables, and returnables used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to implement and maintain an infection prevention and control program designed to provide a safe and sanitary environment to prevent the development and transmission of disease and infections when: 1. Resident 40 was not properly assessed for susceptibility or risk factors prior to being cohorted (group of people who share a room) with Resident 152 who was confirmed to have herpes zoster (shingles-contagious painful, blistering rash). This failure had the potential to result in an avoidable transmission of a communicable disease and potential health complications to Resident 40. 2. a. There was no signage posted outside the room to indicate which resident required transmission-based precaution (TBP-either as standard precaution, contact precautions, droplet and airborne) in Rooms 316. b. There was no signage posted outside the room to indicate the type of precautions Enhanced Based Precautions (EBP-precautions used for residents with wounds, indwelling medical devices or those infected with multidrug resistant organisms (MDRO) requiring gowns and gloves) in Rooms 311, 314, 315, 318, and 321. These failures had the potential to result in the spread of infectious diseases among staff and residents. 3. Two staff members, Certified Nursing Assistant (CNA) 3 and Licensed Vocational Nurse (LVN) 3, did not wear proper personal protective equipment (PPE) while providing care to Resident 15 who was on Enhanced Barrier Precautions (EBP). 4. Two of Two staff (Certified Nurse Assistant [CNA] 5 and Housekeeper [HK] 2) did not follow the facility's policy and procedures for hand hygiene. This failure had the potential to spread germs and cause illnesses. 5. One ice scoop was stored inside the ice bucket during dining service. This failure had the potential to contaminate the ice served to residents. 6. Trash was not properly discarded in the ‘C-Wing' Biohazard room. This failure had the potential to spread germs and cause illnesses. Findings:1.During a review of Resident 40's Face Sheet (demographics), Resident 40 was admitted to the facility on [DATE] with diagnosis of type 2 diabetes mellitus (chronic condition when the body doesn't produce or use sugar effectively). During a concurrent observation and interview on 1/13/2026 at 8:50 a.m. with Resident 40 in his room, there was a PPE cart by the front door, Resident 40 stated his roommate, Resident 152, was on quarantine (staying away from others to minimize contagious spread of a disease) due to having shingles. Resident 40 confirmed he did not have shingles. During a concurrent interview and record review on 1/16/2026 at 9:27 a.m. with Infection Preventionist (IP) 2, Resident 40's full medical record was reviewed. Resident 40's full medical record did not show a history of varicella-zoster virus (chicken pox), a varicella vaccination (shot used to weaken the virus), or an assessment of various risks associated to resident placement with shingles. IP 2 stated Resident 40 should have had a documented assessment for cohorting with a resident who was confirmed to have shingles. IP 2 further stated the assessment should have included a history of chicken pox and vaccination of varicella. During an interview on 1/16/2026 at 9:42 a.m. with the Director of Nursing (DON), the DON stated the IPs should have documented a risk assessment for Resident 40 contracting shingles due to being cohorted with Resident 152. During a review of Resident 152's Physician Orders (PO), dated 1/7/2026, the PO indicated Resident 152 was on Contact Isolation for Shingles. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the CDC's Varicella-Zoster Virus (VZV), Guidelines dated 2/6/2025, the VZV indicated, . Prevention of transmission of VZV in healthcare settings involves ensuring individuals have evidence of immunity to varicella. CDC recommends that susceptible individuals should not enter the room of a patient with. localized herpes zoster. During a review of the facility's policy and procedures (P&P) titled, Resident Isolation- Categories of Transmission-Based Precautions, dated 1/1/2012, the P&P indicated, Contact precautions are implemented for residents known or suspected to be infected or colonized with. Cutaneous Zoster [painful skin rash caused by virus- varicella zoster]. Resident Placement. The resident is placed in a private room. when a private room is not available, the Infection Control Coordinator assesses various risks associated with other resident placement options (e.g., cohorting). 2. During an initial observation on 1/12/2026 at 1:13 p.m. to 3:09 p.m. in Station D, there was an isolation cart set up observed outside the following residents' room (Rooms 311, 314, 315, 316, 318, and 321) which housed two residents per room. The set-up cart included PPE (personal protective equipment-masks, gowns, and gloves). During an interview on 1/13/2026 at 8:19 a.m. with Certified Nursing Assistant (CNA) 7, CNA 7 stated she could not tell what type of isolation precaution was needed for room [ROOM NUMBER], and 318. During a concurrent interview and observation on 1/13/2026 at 9:20 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated she could not tell what type of isolation precaution was needed for room [ROOM NUMBER]. There was an isolation cart observed outside the door. with no signage. During an interview on 1/13/2026 at 9:41 a.m. with Infection Preventionist (IP) 1, IP 1 stated PPE isolation carts should include a clear identification of the type of infection or precaution as well as an indication of which resident is affected. IP 1 could not state what type of isolation precaution was needed for room [ROOM NUMBER] and room [ROOM NUMBER]. During a concurrent interview and record review on 1/15/2026 at 9:14 a.m. with Registered Nurse (RN), 2, RN 2 verified physician's order dated 1/2026 for the residents in the following rooms: room [ROOM NUMBER] A had an order for EBP and Contact Precaution due to infection in the blood room [ROOM NUMBER] B had an order of EBP due to presence of urinary catheter. room [ROOM NUMBER] B had an order of EBP due to intravenous (IV) antibiotic therapy for bone infection. room [ROOM NUMBER] B had an order for EBP precaution due to her infection in the urine and sepsis (blood infection). room [ROOM NUMBER] B had an order for TBP for eye infection. room [ROOM NUMBER] B had an order for EBP due to IV antibiotic therapy for post-surgery. room [ROOM NUMBER] B had an order for EBP for IV antibiotic therapy for infection of the lower extremities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	RN 2 also stated residents who have an order for TBP should have the appropriate PPE in isolation cart outside their room with appropriate signage. The California Department of Public Health (CDPH)'s All Facilities Letter (AFL) 24-15, dated 6/13/2024, the document indicated, California SNFs [Skilled Nursing Facilities] should refer to the CDC website on Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) . for guidance and tools for implementing EBP. CDC's Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 4/2/2024, the document indicated, When implementing. Enhanced Barrier Precautions, it is critical to ensure staff have. access to appropriate supplies. To accomplish this. Make PPE, including gowns and gloves, available immediately outside of the resident room. During a review of the facility's policy and procedure (P&P) titled `Resident Isolation-Categories of Transmission- Bases Precautions dated 1/1/2012 indicated I. Transmission-based precautions are used whenever measures more stringent than standard precautions are needed to prevent or control the spread of infections. During a review of facility's P&P titled IPC303 Enhanced Barrier Precautions with a revised date of 10/15/2024, indicated When transmission-based precautions are not appropriate and in addition to Standard precautions, Enhanced Barrier Precautions will be used . Process .2. For residents for whom EBP are indicated, EBP is employed when performing the following high -contact resident care activities .a. dressing . 5. Post the appropriate Enhanced barrier Precautions sign on the resident's room door to inform caregivers of the appropriate task requiring the use of PPE . 9. To facilitate compliance with EBP: .v. Provide education to residents, legal representatives and visitors as appropriate. 3. During a review of Resident 15's History and Physical (H&P), dated 2/26/2025 by Medical Doctor (MD)1,H&P indicated that Resident 15's present illnesses were dysphagia (difficulty swallowing), a feeding tube, and dementia (decline in thinking). During a concurrent observation and interview on 1/14/2026 at 3:30 p.m. in resident 15's room, observed LVN3 and CNA3 entering room [ROOM NUMBER] wearing gloves and masks. LVN3 was observed turning off and disconnecting Resident 15's feeding tube. LVN3 left the room and CNA3 proceeded to change Resident 15's soiled brief and provide personal hygiene. During an interview, LVN3 indicated the PPE that should have been worn for EBP was mask, gloves, and gown due to Resident 15's feeding tube and doctor's order for EBP. During a review of Resident 15's Physician Order (PO), dated 7/8/2025, the PO indicated Resident 15 was to be on EBP to reduce the spread of infections due to Resident 15's history of multi drug resistant organism and tube feeding. During a review of Resident 15's Care Plan Report (CP), dated 1/15/2026, the CP stated, Utilize PPE during high contact resident care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated 10/15/2024, the P&P indicated, EBP is to be used during high-contact resident care activities . changing briefs. During a review of the All Facilities Letter (AFL- memo issued by the California Department of Public Health) dated 6/13/2024, the AFL indicated skilled nursing facilities should implement Personal Protective Equipment (PPE) to prevent the spread of Multidrug-resistant Organisms (MDRO). Specifically, Enhanced Barrier Precautions (EBP), which involve the use of gloves and a gown during high-contact care activities (person hygiene and linen changes) for residents who have indwelling devices (such as feeding tube), chronic wounds, or MDROs. During a review of CDC recommendations dated 4/2/24, indicated Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities (personal hygiene, linen change, providing medications and treatments such as wound dressing change) for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). 4. During an observation on 1/12/2026 at 4:58 p.m., during dining service, CNA 5 served meal trays to multiple residents without performing hand hygiene between resident contacts. CNA 5 also did not perform hand hygiene after donning (putting on) a hair net. During an interview on 1/12/2026 at 5:07 p.m., with CNA 5, CNA 5 acknowledged they did not perform hand hygiene in between resident contacts. CNA 5 confirmed they completed hand hygiene training but did not perform hand hygiene as required to prevent the spread of illness. During a concurrent observation and interview on 1/13/2026 at 11:10 a.m., with HK 2, in the 'C-Wing' Hallway, HK 2 handled soiled trash from the housekeeping cart with ungloved hands and disposed of it in the biohazard room. HK 2 then exited the room without performing hand hygiene and placed hands into their uniform pocket. HK 2 stated their usual practice was to perform hand hygiene after discarding trash, however failed to do so at the time of the observation. During an interview on 1/15/2026 at 4:10 p.m., with Infection Preventionist (IP) 2, IP 2 stated CNA 5 and HK 2 did not follow facility policy for hand hygiene. IP 2 stated it was the expectation that staff performed hand hygiene in between tasks, when leaving resident rooms, and when visibly soiled to prevent cross contamination and the spread of diseases within the facility. During a review of the facility's P&P titled Hand Hygiene dated 9/01/2020, the P&P indicated, .The Facility Considers hand hygiene as the primary means to prevent the spread of infections .Facility , healthcare personnel (HCP), Residents, visitors, and volunteers must perform hand hygiene to prevent the transmission of HAIs [healthcare-associated infections] .The following situations require appropriate hand hygiene . before and after assisting a resident with dining .when hands are visibly soiled . 5. During an observation on 1/12/2026 at 4:30 p.m., in the dining room, staff served resident meal trays. One blue ice scoop (a small shovel used to serve ice cubes) was stored in a bucket filled with ice on the 'Drink service cart'. Staff served residents ice in their cups then returned the scoop to the ice bucket. Staff repeated this process throughout the dining service. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/12/2026 at 4:52 p.m., with CNA 4, CNA 4 stated they were not aware of the facility's policy that addressed whether ice scoops may be stored inside ice buckets but reported the ice scoops on the units were stored separately. CNA 4 stated the 'Drink service cart' was prepped for service by kitchen staff with the ice scoop already stored in the ice bucket. During an interview on 1/12/2026 at 5:16 p.m., with the Certified Dietary Manager (DM), the DM stated ice scoops should be stored separately from the ice. The DM stated repeatedly touching the ice scoop and putting it back into the ice bucket should not be done to avoid contamination of the ice. The DM stated staff required reeducation on the proper handling of the ice. During an interview on 1/15/2026 at 4:10 p.m., with IP 2, IP 2 stated the facility followed the Centers for Disease Control and Prevention (CDC- the national public health agency of the United States) guidelines for infection prevention and control practices utilized in the facility. A review of the CDC's document titled Part II. Recommendations for Environmental Infection Control in Health-Care Facilities dated 1/11/2024, indicated, .Do not handle ice directly by hand, and wash hands before obtaining ice .Do not store the ice scoop in the ice bin. 6. During a concurrent observation and interview on 1/12/2026 at 2:27 p.m., with HK 1, in the 'C-Wing' Biohazard room, there was a cluttered area that contained nine bags of trash, one plastic container with yellow fluid, and cardboard boxes that were stacked on the biohazard receptacle (bin) and room counter. Trash bags were also stuffed underneath the counter. The large black trash bin used to store and transport trash was empty. During an interview on 1/13/2026 at 10:10 a.m., with the Environmental Services Manager (ESM), the ESM stated facility trash was not collected at the regular scheduled time, therefore the trash was left on the floor. The ESM stated the trash was removed from the bin to make room for the excess and that this practice occurred on occasion when the trash not picked up by the vendor. The ESM stated there was no process in place to address the excess trash when not collected as scheduled. During an interview on 1/15/2026 at 4:10 p.m., with IP 2, IP 2 stated discarded trash left on the floor was unsanitary. The IP 2 stated trash should be stored in the appropriate containers to prevent contamination and transmission of germs. The IP 2 stated she was aware that trash service was delayed, however staff should have promptly removed the trash from the floor and stored the trash in the assigned trash bin. During a review of the facility's P&P titled Medical Waste- Containers and Storage dated 1/01/2012, the P&P indicated, .waste is stored so that it is protected from animals and does not provide a breeding place or a food source for insects and rodents .The infection control coordinator or designee monitors the medical waste storage areas to assure that medical waste is treated, disposed of, or picked up by the authorized vendor on a timely basis .

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	555256	A. Building B. Wing	01/16/2026

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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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure oversight and monitoring of antibiotic use for one of 29 sampled residents (Resident 44) when Resident 44 was administered two separate antibiotics without documented indication and appropriate physician review. This failure resulted in Resident 44 receiving two unnecessary medications with the possibility of adverse drug reactions and antibiotic resistance.Cross reference to F757Findings:During a review of Resident 44's Face Sheet, Resident 44 was admitted to the facility on [DATE] with diagnoses to include chronic kidney disease stage 3, and type 2 diabetes mellitus (chronic condition when the body doesn't produce or use sugar effectively).During a concurrent interview and record review on 1/16/2026 at 9:18 a.m. with Infection Preventionist (IP) 2, the following documents were reviewed:-Resident 44's Physician Orders (PO), dated 12/16/2025, the PO indicated to administer azithromycin 500 mg (milligram-unit of measurement) for three days for ppx (prophylactic-used for preventive measures).-Resident 44's PO, revised on 12/16/2025, the PO indicated to administer cefdinir 300 mg twice a day for 10 days for UTI (urinary tract infection- infection in the bladder, kidney or tube the urine travels through to exit the body).-Resident 44's Lab Results Report, dated 12/15/2025, the report indicated Resident 44 had a urine sample tested and the urine culture does not meet the UTI criteria. According to recent guidelines by multiple clinical societies, antibiotic therapy is not recommended . -Resident 44's Medication Administration Record (MAR), dated December 2025, the MAR confirmed Resident 44 received 13 doses of Cefdinir from 12/12/2025 to 12/18/2025 and three doses of Azithromycin from 12/16/2025 to 12/18/2025. -Facility Antibiotic tracking log, undated, the Antibiotic tracking log indicated Resident 44 was not being monitored for antibiotic use of azithromycin and cefdinir.The IP 2 confirmed there was no tracking or monitoring for Resident 44 while receiving two different antibiotics and stated Resident 44 should have been monitored by the IPs for antibiotic usage.During a review of the facility's policy and procedures (P&P) titled, Antibiotic Stewardship, dated 5/20/2021, the P&P indicated, The IP is responsible for tracking the following antibiotic stewardship processes. The antibiotic ordered, dose, route, and ordering physician as well as the cost of the drug. Whether or not the resident's condition met McGeer's Criteria [standardized set of rules used in nursing homes to consistently identify when a resident has an infection such as a UTI] when the antibiotic was ordered. if cultures were ordered. any changes in antibiotic orders during therapy. Outcomes of antibiotic therapy. The IP will provide results of tracking antibiotic use.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure documentation was maintained to verify that influenza (a highly contagious viral infection of the respiratory tract) and pneumococcal (a bacterial infection that may cause pneumonia and other serious illnesses) immunizations were offered in accordance with facility policy to one of five residents (Resident 2) reviewed for immunizations. This failure placed Resident 2 at risk for acquiring influenza and/or pneumococcal disease.During a review of Resident 2's face sheet (a document containing demographic information), it was noted that the resident was admitted to the facility on [DATE] with diagnoses that included Metabolic Encephalopathy (brain dysfunction caused by a chemical imbalance related to an underlying illness) and Pneumonitis (inflammation of lung tissue) due to aspiration of food and vomit.During a concurrent interview and record review on 1/15/2026 at 9:24 a.m. with the Infection Preventionist (IP) 2, IP 2 stated she was unable to locate documentation in the Resident 2's electronic medical record indicating that influenza and pneumococcal vaccines were offered or administered. IP 2 stated these immunizations should have been offered; however, the documentation was missing. Resident 2 was admitted to the facility on [DATE].During a review of the facility P&P titled, Pneumococcal Vaccination, dated 4/27/2023, the P&P indicated, .The facility will provide all residents the opportunity to receive the pneumococcal vaccine, unless it is medically contraindicated, or the Resident is already immunized according to the Centers for Disease Prevention and Control recommendations or state/local public health guidelines. To prevent pneumococcal disease and its complications to residents. To properly administer pneumococcal vaccination and monitor for complications .During a review of the facility policy and procedure (P&P) titled, Influenza Prevention and Control, dated October 2020, P&P indicated, .The facility will follow infection prevention and control policies and procedures to minimize the risk of Residents acquiring, transmitting or experiencing complications from influenza. Before offering the influenza vaccine, each Resident or the Resident's representative will be given education regarding the risk and benefits and potential side effects of the immunization. The CDC Vaccination Information Statement (VIS) will be used as part of the Resident's (representative's) education. B. Residents are offered an influenza immunization every year during flu season, unless the immunization is medically contraindicated, or the Resident has already been immunized during the current flu season. C. The Resident or representative must give consent prior to receiving the vaccine. They can refuse the immunization-with such refusal being noted in the Resident's medical record. 4. The Resident's medical record will include documentation that indicates, at a minimum, the following: i. The Resident or the Resident's representative was provided education regarding the risk and benefits and potential side effects of the influenza vaccination.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow infection prevention and control procedures for COVID-19 (a highly contagious respiratory infection) in accordance with the facility's vaccination policy, when:1. Resident 124 declined the COVID-19 vaccination; however, there was no documentation that the facility provided education regarding the risks and benefits of the vaccine. This failure posed the potential risk of COVID-19 transmission and compromised Resident 124's ability to make an informed decision regarding vaccination. 2. There was no documentation verifying Certified Nursing Assistant (CNA 1) was vaccinated for influenza and COVID-19. This failure risked 146 residents at risk of exposure of influenza and COVID-19.1. During a review of Resident 124's face sheet (a document containing demographic information), it was noted that the resident was admitted to the facility on [DATE] with a diagnosis that included Diabetes Mellitus (a chronic disease associated with abnormally high levels of the sugar glucose in the blood). During a concurrent interview and record review on 1/15/2026 at 9:39 a.m. with the Infection Preventionist (IP) 2, IP 2 stated that Resident 124 declined the COVID-19 vaccination. IP 2 further stated that she was unable to locate documentation indicating that the facility had provided education regarding the risks and benefits of the vaccine to Resident 124 or the resident's responsible party.During a review of the facility P&P titled, COVID-19 Vaccination Program, date 4/27/2023, the P&P indicated, . The Facility will offer SARS-CoV-2 vaccinations (including additional and booster doses) to all Residents. They will be encouraged but are not required to be vaccinated or boosted. In this case, all requirements of education, consent, administration, reporting and documentation will be the responsibility of the Facility.2. During a concurrent interview and record review on 1/15/2026 at 10:05 a.m. with the IP 2, IP 2 stated CNA 1 had consented to the influenza and COVID-19 vaccines; however, there was no documentation provided, confirming that the vaccines were administered.During a review of the facility P&P titled, COVID-19 Vaccination Program, date 4/27/2023, the P&P indicated, . All Health Care Personnel (HCP) are required to be fully vaccinated.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide training consistent with the facility assessment and resident population when the facility did not provide training for malnutrition (poor nutrition) and seizures (uncontrolled, abnormal electrical activity of the brain). This failure to provide adequate training to staff caring for residents with malnutrition and/or seizure disorders delayed recognition of critical symptoms and appropriate interventions and placed residents at risk for injury. Cross reference; F692, F658 Findings: During review of the facility document titled [Name] Facility Assessment dated 12/15/2025, indicated, . Average facility daily census: (range) 140 .Top 25 diagnosis .Protein calorie malnutrition (22) .Epilepsy (13) [a brain condition causing recurrent seizures] . Based on the 'Facility Assessment', one quarter of the facility's total resident population had a diagnosis of malnutrition and/ or seizure type disorders. During a concurrent interview and employee record review on 1/5/2026 at 2:52 p.m., with the Director of Staff Development (DSD), the DSD stated the facility did not provide malnutrition or seizure type disorder and intervention training to staff. The DSD stated they did not consider the 'Facility Assessment' when choosing training topics. The DSD acknowledged the identified learning need to support the delivery of effective care and reduce the risk of injury for facility residents with malnutrition and/ or seizure type diagnoses. During an interview on 1/16/2026 at 9:00 a.m., with the Director of Nursing (DON), The DON acknowledged, based on the 'Facility Assessment', the facility had a large number of residents with malnutrition and seizure type diagnoses. The DON stated identification and management of malnutrition was not provided to all staff and there was no staff training provided regarding seizures and seizure precautions. During a review of the facility policy and procedure (P&P) titled Facility Assessment dated 4/15/2021, the P&P indicated, . To evaluate the Resident population and identify the resources needed to provide the necessary care and services required during both day-to-day operations and emergencies . The facility team will conduct a thorough review, analysis and trending of the collected data, assessing the needs of the resident population and identifying resources needed for care and service delivery .