STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555256	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow their policy and procedure to ensure the safety of a resident (Resident 1) after Resident 1 did not return from a scheduled doctor's appointment. This failure had the potential to negatively affect the safety and well-being of Resident 1. Findings: During a review of the Resident 1's clinical record the Face Sheet (FS) dated 1/9/20, indicated Resident 1 was admitted on [DATE]. Resident 1's FS indicated he had pressure injury (PI) sacral region stage four (a very deep injury to skin reaching into muscle and bone and causing extensive damage), osteo[DIAGNOSES REDACTED] (an infection of the bone, a rare but serious condition), and [MEDICAL CONDITION] (paralysis of the legs and lower body, typically caused by spinal injury or disease). Resident 1's PO dated 1/26/19, indicated Resident 1 had a doctor's scheduled appointment on 1/31/20, at 2:45 PM. Resident 1's PO dated 1/26/19, indicated Resident 1 had daily dressing changes for stage four PI to the sacrum. During a review of Resident 1's Social Service Progress Notes (SSPN), the SSPN dated 1/31/20, indicated Resident 1 went out to an appointment and did not return. An attempt was made to contact daughter, no answer, a message was left, and Ombudsman notified. SSPN dated 2/3/20 (three days after Resident 1 did not return), indicated incident was reported to Ombudsman and Adult Protective Services (APS). SSPN dated 2/4/20 (four days after Resident 1 did not return), indicated incident was reported to the police. During an interview on 2/5/20, at 10:54 AM, with Social Services (SS), SS stated when she returned back to work on 2/3/20, I was like wow he still isn't back! SS stated she called the police on 2/4/20. SS confirmed she did not know if Resident 1 was safe because the facility was not able to contact Resident 1 or Resident 1's family members. She confirmed Resident 1 was at risk due to his PI and disabilities. During an interview on 2/5/20, at 11:35 AM, with Director of Nurse (DON), DON stated she was notified on 1/31/20 that Resident 1 did not return from his appointment. DON stated she directed the nurse to continue to try and reach Resident 1 and responsible party (RP). She stated, I assumed that he came back. She stated she never received any other calls in regards to Resident 1. DON confirmed Resident 1 had an increased risk of infection related to PI, and needed daily dressing changes. She confirmed Resident 1 would not be able to change his own dressings due to disability and location of PI. During a concurrent interview and record review for Resident 1, on 2/5/20, at 3:39 PM, with LVN 1, LVN 1 stated on 1/31/20 at 8 PM Resident 1 was not back from his appointment. LVN 1 stated she called his home two times and she called the RP (Resident 1's daughter). LVN 1 stated she informed MD, Administrator, and DON of Resident 1's absence. LVN 1 stated she was directed to continue to try reach Resident 1. LVN 1 stated she called three more time and was not able to contact Resident 1 or his daughter. LVN 1 stated she did not call and update MD, Administrator, or DON. LVN 1 stated, I was hoping he would come back. LVN 1 stated she reported that Resident 1 had not come back from his doctor's appointment to the oncoming nurse. LVN 1 stated the next day she received report he still had not returned. LVN 1 confirmed there was no nursing documentation after 2/1/20 at 1:30 PM related to Resident 1's absence. LVN 1 confirmed she did not know where Resident 1 was or if Resident 1 was safe. LVN 1 stated she should have called the police. During an interview on, 2/5/20, at 4:46 PM, with Administrator, Administrator stated on 2/2/20 he was aware Resident 1 had not returned to the facility. Administrator confirmed he was not able to contact Resident 1. Administrator confirmed he did not know where Resident 1 was or if Resident 1 was safe. During a concurrent interview and review of the clinical record for Resident 1, on [DATE], at 1:51 PM, with LVN 2, LVN 2 stated she received report that Resident 1 had not returned from his doctor's appointment. She stated she tried to call Resident 1's daughter but there was no answer. LVN 2 confirmed her documentation dated 2/1/20 at 1:30 PM was the last time a nurse documented in Resident 1's nursing notes. LVN5 stated Resident 1 had a stage four PI with daily dressing changes, she confirmed Resident 1 would not be able to change his dressings due to the location and disability. LVN 2 confirmed the PI would put him at higher risk for infection. LVN 2 confirmed there were no discharge orders, and Resident 1 would still be the facilities responsibility. LVN 2 confirmed she did not know where Resident 1 was or if Resident 1 was safe. LVN 2 stated when a resident is missing we notify MD, DON, Administrator, and call the police. During a concurrent interview and review of the clinical record for Resident 1, on [DATE], at 2 PM, with DON, DON confirmed there were no discharge orders noted in Resident 1's record. She stated we notified MD on 2/3/20 that Resident 1 had not returned from his doctor's appointment on 1/31/20. During a review of the facility's policy and procedure (P&P) titled, Wandering & Elopement, revised 7/17, the P&P indicated Purpose To enhance the safety of the residents of the Facility. Policy The Facility will identify residents at risk for elopement and minimize any possible injury as a result of elopement. C. If the resident cannot be located, the Charge Nurse will notify: I. Administrator/designee ii. Director of Nursing Services/designee iii. Attending Physician iv. Responsible Party D. The Administrator/designee will contact local law enforcement.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.