STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555116	A. BUILDING **02** B. WING _____	**11/12/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD HEALTH FACILITY	**1401 NEW STINE ROAD** **BAKERSFIELD, CA 93309**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. The facility is in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census = 72	E 000		
K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 7/9/79 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. Resident Certified Beds: 79 Resident Census: 72 The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition.	K 000		
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall	K 741		12/17/24

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

Electronically Signed | 11/27/2024

12/2/24 POC approved by Beverly Ong Sladek, SSM-I

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K 741	Continued From page 1 include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the smoking regulations. This was evidenced by tobacco materials that were not disposed into an ashtray with a self-closing device. This could lead to an incipient fire, and affected the Smoking Designated Area. Finding: During a tour of the facility and interview with the Safety Officer on 11/12/24, the smoking area was observed.	K 741	Preparation and execution of this response and Plan of Correction does not constitute an admission or agreement by HumanGood NorCal/Rosewood Health Facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies and Plan of Correction. The Plan of Correction is being prepared and/or executed solely because it is required by State and Federal Law. For the purposes of any allegation that the facility is not in substantial compliance	

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K 741	Continued From page 2 At 1:39 p.m., the facility failed to provide an ashtray with a safe design in the smoking designated area. There were over 30 cigarette butts inside a metal container that did have have a self-closing device. During a concurrent interview, the Safety Officer confirmed the finding and stated that the facility does not have many residents that smoke.	K 741	with Federal requirements of participation, this Response and Plan of Correction constitutes the facility□s allegation of compliance in accordance with section 7305 of the State Operations Manual. This written plan of correction serves as our allegation of compliance. This facility will be in substantial compliance by 12/17/2024. 1. How corrective actions will be accomplished for those Residents found to have been affected by the deficient practice: Immediately removed the one unapproved metal container from the smoking area leaving two that meets the Ashrae approval requirements. (11/12/2024) 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All Residents had the potential of being affect by this alleged deficient practice. Initiated in-service to all staff on the Smoking policy and procedure. (11/20/24) 3. What measures will be put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: Revised the Smoking policy and will be reviewed in QAPI. (11/19/2024) Safety Officer/Designee initiated in-service to all staff on the Smoking policy and Procedure. (11/20/24) Revised the Life Safety daily rounding checklist to include the smoking area. (11/21/24) Preventative maintenance work order will	

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K 741	Continued From page 3	K 741	be generated in the (Computerized Maintenance Management System) CMMS for daily inspection of designated smoking area. (11/21/24) Educational training of the Smoking Policy will be provided to Team upon hirer and annually. Maintenance Department/Designee to monitor designated Smoking area daily for compliance with the Smoking policy. (11/21/24) Safety Officer/Designee to spot audit Smoking area weekly for compliance with the Smoking Policy. (11/21/24) 4. How the facility plans to monitor its performance to make sure that solutions are sustained: Maintenance/Designee will inspect designated smoking area for compliance with metal containers having a lid daily (x2 weeks), once weekly (x2 weeks), bi-monthly (x1 month), once monthly (x1 month) and random thereafter up to 2 months. Safety Officer/Designee will Report findings to QA monthly x 3 months until resolved. Safety officer/Designee will report the QIC reviews quarterly to QAPI for discussions/ recommendations. Director of Building and Grounds responsible for compliance. 5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency. Completion date: 12/17/24 Tracie Fairley, HSA	

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K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced	K 923		12/17/24

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K 923	Continued From page 5 by: Based on observation and interview, the facility failed to maintain the oxygen cylinder storage areas. This was evidenced by the failure to separate oxygen cylinders located in the same enclosure, and by the failure to secure the door to oxygen cylinders from unauthorized access. This could result in confusion during an emergency. This affected the Service Corridor and Patio Area. NFPA 99, Health Care Facilities Code, 2012 Edition 11.3.2 *Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. 11.6.5 Special Precautions - Storage of Cylinders and Containers. 11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. 11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. 11.6.5.2.1 When the facility employs cylinders with integral pressure gauge, it shall establish the threshold pressure at which a cylinder is considered empty. 11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner. Findings:	K 923	Preparation and execution of this response and Plan of Correction does not constitute an admission or agreement by HumanGood NorCal/Rosewood Health Facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies and Plan of Correction. The Plan of Correction is being prepared and/or executed solely because it is required by State and Federal Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this Response and Plan of Correction constitutes the facility□s allegation of compliance in accordance with section 7305 of the State Operations Manual. This written plan of correction serves as our allegation of compliance. This facility will be in substantial compliance by 12/17/2024. 1. How corrective actions will be accomplished for those Residents found to have been affected by the deficient practice: Removed the extra empty E-Cylinders for compliance with NFPA 99 2012 edition Gas Equipment- Cylinder and Container Storage. (11/12/2024) Purchased/installed a lock for the outside Oxygen cylinder storage. (11/12/24) 2. How the facility will identify other residents to be affected by the same deficient practice and what corrective action will be taken: All Residents had the potential of being	

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K 923	Continued From page 6 During a tour of the facility and interview with the Safety Officer, Assistant Director of Nursing, and Administrator on 11/13/24, the oxygen storage areas were observed. 1. At 1:26 p.m., the Oxygen Storage Room was observed. The room contained approximately 408 cubic feet of oxygen. There was one empty oxygen "E" cylinder mixed with the full rack. There were five cylinders on handcarts. The cylinders were used and they were closer to the full rack than the empty. During a concurrent interview, the Safety Office confirmed the finding and stated that there was a second storage area in the Patio. 2. At 4:15 p.m., the Patio Oxygen Storage closet was observed. The storage closet contained 456 cubic feet of oxygen. The storage doors were not secured from unauthorized access and there was no staff supervision in the area. During a concurrent interview, the Safety Officer confirmed the finding and stated that closet was chained to the post but the doors were not secured.	K 923	affected by this alleged deficient practice. Removed the extra empty E-Cylinders for compliance with NFPA 99 2012 edition. (11/12/2024) Purchased/installed a lock for outside Oxygen cylinder storage. (11/12/24) 3. What measures will be put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: Oxygen Storage Policy created and will be reviewed in QAPI. (11/24/24) DSD/Designee initiated in-service to staff on NFPA 99 2012 regulations Gas Equipment- Cylinder and Container Storage. (11/12/24) Implement an Oxygen Cylinder Storage training schedule to include training of staff annually. Revised the Life Safety daily rounding checklist to include Oxygen cylinder storage and secured access. (11/21/24) Preventative maintenance work order will be generated in the (Computerized Maintenance Management System) CMMS for daily inspection of Oxygen cylinder storage area. (11/21/24) Created Oxygen cylinder storage check audit tool. (11/21/24) Maintenance Department/Designee to inspect designated Oxygen cylinder storage area daily for compliance with the Oxygen Storage policy. (11/21/24) Safety Officer/Designee will spot audit the Oxygen cylinder storage areas weekly for compliance with Oxygen Storage policy and procedure. (11/21/24) 4. How the facility plans to monitor its	

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K 923	Continued From page 7	K 923	performance to make sure that solutions are sustained: Maintenance Department/Designee will inspect Oxygen cylinder storage areas for compliance with Oxygen cylinder storage policy daily (x2 weeks), once weekly (x2 weeks), bi-monthly (x1 month), once monthly (x1 month) and random thereafter up to 2 months. Safety Officer/Designee will Report findings to QA monthly x 3 months until resolved. Safety officer/Designee will report the QIC reviews quarterly to QAPI for discussions/ recommendations The Director of Building and Grounds is responsible for compliance 5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency. Completion date: 12/17/24 Tracie Fairley, HSA	
K 926 SS=E	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 926		12/17/24

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K 926	Continued From page 8 Based on observation and interview, the facility failed to maintain the medical gas equipment. This was evidenced by missing the continuing education for staff associated with the safe handling of oxygen gas, and by missing a policy and procedure. This could result in the unsafe use and handling of medical gas equipment. This affected 72 of 72 residents in four of four smoke compartments. NFPA 99 Health Care Facilities Code, 2012 Editions 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1 * Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders. 11.5.2.1.4 Equipment shall be serviced only by personnel trained in the maintenance and operation of the equipment. 11.6.1 Administration. Administrative authorities of health care organizations shall provide policies and procedures for safe practices. Findings: During a tour of the facility and interview with the Safety Officer, Assistant Director of Nursing, and Administrator on 11/12/24, documentation was requested.	K 926	Preparation and execution of this response and Plan of Correction does not constitute an admission or agreement by HumanGood NorCal/Rosewood Health Facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies and Plan of Correction. The Plan of Correction is being prepared and/or executed solely because it is required by State and Federal Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this Response and Plan of Correction constitutes the facility□s allegation of compliance in accordance with section 7305 of the State Operations Manual. This written plan of correction serves as our allegation of compliance. This facility will be in substantial compliance by 12/17/2024. 1. How corrective actions will be accomplished for those Residents found to have been affected by the deficient practice: Immediately initiated in-service to team members on NFPA 99 2012 edition Gas Equipment- Cylinder and Container Storage/Handling. (11/12/2024) 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All Residents had the potential of being affected by this alleged deficient practice. Initiated in-service to team members on	

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K 926	Continued From page 9 1. At 1:27 p.m., the facility failed to provide staff with continuing education for the safe handling of medical gases. The facility had approximately 408 cubic feet of oxygen indoor and approximately 456 cubic feet of oxygen outdoor. During a concurrent interview, the Assistant Director of Nursing stated that she will look for the in-services. At 2:30 p.m., the Administrator stated that the facility did not have a record of continuing education for staff associated with the safe handling and storage of oxygen. 2. At 4:44 p.m., the facility failed to provide a policy and procedure for handling and storage of oxygen. During a concurrent interview, the Administrator stated that she could not locate the policy.	K 926	NFPA 99 2012 edition Gas Equipment-Cylinder and Container Storage/Handling (11/12/24) 3. What measures will be put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: Oxygen Storage Policy created and will be reviewed in QAPI. (11/24/24) DSD/Designee initiated in-service of staff on NFPA 99 2012 edition Gas Equipment-Cylinder and Container Storage. (11/12/24) Implemented an Oxygen Cylinder Storage training schedule to include training at orientation and annually. Created an Oxygen Storage policy competency test. (11/24/24) Safety Officer/ Designee will randomly quiz team members weekly for competency of Oxygen Storage Policy and provide on the spot correction if needed. (11/27/24) 4. How the facility plans to monitor its performance to make sure that solutions are sustained: Safety Officer/Designee will audit the results of six Team Members quizzes weekly (x4 weeks), then weekly (x4 weeks), bi-monthly (1 month) and random spot check thereafter for two months. Safety Officer/Designee will Report findings to QA monthly x 3 months until resolved. Safety officer/Designee will report the QIC reviews quarterly to QAPI for discussions/ recommendations. Safety Officer will be responsible for compliance.	

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K 926	Continued From page 10	K 926	5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency. Completion date: 12/17/24 Tracie Fairley, HSA	