

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>555260</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>10/13/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>WINDSOR POST-ACUTE CENTER OF BAKERSFIELD</b>		STREET ADDRESS, CITY, STATE, ZIP <b>6212 TUDOR WAY BAKERSFIELD, CA 93306</b>	
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 0677  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<b>Provide care and assistance to perform activities of daily living for any resident who is unable.</b> <b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide the needed shower for one of three sampled residents (Resident 1). This failure resulted in not providing the needs of Resident 1 for personal hygiene affecting his quality of life. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, Resident 1 was admitted on [DATE], with a [DIAGNOSES REDACTED]. During a review of Resident 1's Minimum Data Set (MDS-an assessment tool), dated 8/31/2020, the MDS indicated, Resident 1's BIMS (Brief Interview for Mental Status - a tool used to evaluate cognitive function) score was 15 (13-15 indicates cognitively intact). During a review of Resident 1's Shower List (SL), undated, the SL indicated, Resident 1's scheduled shower days are every Wednesday and Saturday. During an interview on 7/29/2020, at 1:46 PM, with Resident 1, Resident 1 stated, I only had a shower once last week and none the week before that. They said they don't have time. I sweat a lot so I don't want to smell. It's embarrassing. During a concurrent interview and record review on 7/29/2020, at 2:41 PM, with the Director of Nursing (DON), Resident 1's July 2020 Plan of Care Response History (POC) was reviewed. DON was unable to find documented evidence Resident 1 received a shower on his scheduled shower days. DON stated, My expectation is for them to give showers as scheduled. If the resident refused, they need to let the nurses know. During a concurrent interview and record review on 9/28/2020, at 11:32 AM, with the Minimum Data Set Coordinator (MDSC), Resident 1's POC for July 2020 was reviewed. MDSC stated, (Resident 1) was in the Covid-19 (COVID - an infectious disease caused by a new [MEDICAL CONDITION]) unit from 6/29/2020 to 7/7/2020 and they don't do showers in that unit. His normal shower routine should have continued as soon as he was transferred back to his room. MDS confirmed that no documented evidence of showers were provided for Resident 1 on the following days: Wednesday, 7/8/2020 Saturday, 7/11/2020 Wednesday, 7/15/2020 Saturday, 7/18/2020 During a concurrent interview and record review, on 10/1/2020, at 11:56 PM, with Certified Nursing Assistant (CNA) assigned to the shower team, Resident 1's Shower Task for July 2020 was reviewed. CNA stated, (Resident 1) never refuses his showers. It looks like it wasn't given to him on those days. During an interview on 10/1/2020, at 12 N, with Licensed Vocational Nurse (LVN), LVN stated there were no reported shower refusals by Resident 1 for the month of July 2020. During a review of the facility's policy and procedure (P&P) titled, Your Rights and Protection as a Nursing Home Resident, undated, the P&P indicated, Federal law specifies that nursing homes must protect and promote the following rights of each resident. You have the right to be treated with dignity and respect, as well as make your own schedule and participate in the activities you choose. During a review of the facility's P&P titled, Bathing, dated 11/12, the P&P indicated, It is the policy of (Facility) to ensure that residents are kept clean and free of odors by routine bathing in a safe and comfortable manner.		

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.