STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055601	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Julian Healthcare Center	1801 Julian Avenue Bakersfield, CA 93304

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 39763 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Abuse Prevention and Prohibition Program, when the facility failed to: 1. Submit the SOC 341 (California Report of Suspected Dependent/Elder Abuse) to the California Department of Public Health (CDPH - local state agency) and local ombudsman for two of five sampled residents (Resident 1 and Resident 2). This failure had the potential for Resident 1 and Resident 2 to experience further abuse. 2. Submit the 5-day investigation report to the local ombudsman and the CDPH within 5-days of the incident for one of five sampled residents (Resident 3). This failure had the potential for an incomplete investigation for Resident 3. 3. Notify the attending physician (AP) for one of five sampled residents (Resident 3) allegation of financial abuse. This failure resulted in Resident 3's AP to be unaware of the financial abuse. 4. Develop a care plan for one of five sampled residents (Resident 3) when the financial abuse was discovered. This failure had the potential for Resident 3 mental or psychosocial change to go unnoticed and Resident 3 mental or psychosocial needs to go unmet. Findings: 1. During an interview on 2/26/25 at 11:34 a.m. with Director of Nursing (DON), DON confirmed Resident 1 and Resident 2 had an unwitnessed resident to resident altercation on 2/17/25. DON was unable to provide documentation the SOC 341 was sent timely to CDPH or local ombudsman. DON stated there was an error in communication and the SOC 341 was not sent timely. 2. During a concurrent interview and record review on 3/4/25 at 3 p.m. with DON, the SOC 341 dated 2/26/25 indicated, Resident 3 was a victim of financial abuse. DON stated the 5-day investigation report was not available at this time (6 days). 3. During a concurrent interview and record review on 3/4/25 at 2:14 p.m. with DON, Resident 3 medical record was reviewed. DON confirmed there was no documentation Resident 3's AP was notified of the allegation of financial abuse. DON stated Resident 3's AP should have been notified. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a concurrent interview and record review on 3/4/25 at 2:14 p.m. with DON, Resident 3's medical record was reviewed. DON stated there was no care plan developed or implemented to assess or monitor for mental or psychosocial outcomes or needs after Resident 3's financial abuse was discovered. During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention and Prohibition Program, revise 8/1/23, the P&P indicated, To ensure the Facility establishes, operationalizes, and maintains and Abuse Prevention and Prohibition Program designed to . protect residents, and ensure a standardized methodology for the . reporting of abuse . in accordance with federal and state requirements. III. The Administrator is responsible for coordinating and implementing the Facility's abuse prevention policies, procedures, . and systems. Reporting/Response . The Facility will report allegations of abuse . using . California Report of Suspected Dependent/Elder Abuse (SOC 341) . i. immediately, but no later than 2 hours after forming the suspicion- if the alleged violation involves abuse . to the state survey agency, adult protective services, law enforcement and Ombudsman. ii. No later than 24 hours after forming the suspicion - if the alleged violation .does not involve abuse and does not result in serious bodily to the state survey agency, adult protective services, law enforcement and Ombudsman. iii. Reporting requirements are based on real (clock) time, not business hours. iv. The Administrator will provide the state survey agency, law enforcement and the Ombudsman with a copy of the investigation report within 5 days of the incident. vi. The resident's Attending Physician . will also be notified of the allegation and outcome of the investigation. XI. The Facility will reassess the resident following the investigation to determine if the resident's medical, nursing, physical, mental or psychosocial needs or preferences have changed as a result of the incident and initiate or update the care plan as indicated.