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	03/13/2025

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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50409 Based on interview and record review, the facility failed to follow one of three sampled residents (Resident 1) care plan (personalized plan of care outlining a person's needs and how they will be addressed) to ensure Resident 1 who was high risk for falls (to move downward, typically rapidly and freely without control, from a higher to a lower level), had history of falls, and had Alzheimer's disease (progressive and fatal brain disorder that causes memory loss, cognitive decline [gradual decrease in mental abilities, such as memory, attention, reasoning, and judgment], and behavioral changes), had a floor mat (cushioned floor covering designed to reduce the impact of a fall, minimizing the risk of injury) to the right side of the bed and was wearing nonskid (designed to prevent sliding or skidding) socks when he got out of bed. These failures resulted in Resident 1 sustaining a fall and experiencing pain to the right hip. Resident 1 was transferred to the acute hospital requiring admission and operation for the acute (new) intertrochanteric (bony bumps on the upper part of the thigh bone) right femoral (relating to the thigh) fracture (broken bone). Findings: During a review of Resident 1's Admission Record (AR), dated 3/13/25, the AR indicated, Resident 1 was admitted on [DATE]. The AR indicated, Diagnosis. Hemiplegia (paralysis on one side of the body) and Hemiparesis (weakness on one side of the body) Following Other Cerebrovascular Disease (condition that affects blood flow to the brain) Affecting Left Non-Dominant Side (side of the body that is not used as much as the other side for everyday tasks) . Muscle Weakness (Generalized). Other Abnormalities of Gait and Mobility (change in walking pattern) . Alzheimer's disease. During a review of Resident 1's Quarterly Minimum Data Set (MDS - an assessment tool), dated 2/3/25, the MDS indicated, under Section C (Cognitive Patterns - the ways people think, process information, and make judgments) Resident 1 had a BIMS (Brief Interview for Mental Status) score of 5 (score of 0 - 7 indicates severe cognitive impairment [decline in one or more mental abilities that affects a person's daily functioning]). The MDS indicated, under Section GG (Functional Abilities - a person's capacity to perform everyday activities) Resident 1's admission performance required substantial or maximal assistance (helper does more than half the effort) with putting on or taking off footwear. The MDS indicated walking was not attempted due to safety concerns (Resident 1 was not walking at the time of assessment). (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Fall Risk Evaluation (FRE - process used to identify factors that increase an individual's likelihood of falling), dated 2/1/25, the FRE indicated Resident 1 had a score of 15 (score of 10 or higher indicates high risk for falls). During a review of Resident 1's Care Plan (CP), dated 10/14/24 (current care plan on 3/5/25), the CP indicated, High risk for repeated falls. Interventions. Ensure that the resident is wearing appropriate footwear when ambulating. During a review of Resident 1's CP, dated 10/28/24 (current care plan on 3/5/25), the CP indicated, High risk for repeated falls. Interventions. Floor mat to Right side of bed (Resident 1's left side of the bed has the window, and his right side of the bed has the floor space between his bed and the roommate's bed). During a review of Resident 1's Post Fall Evaluation (PFE - assessment after a fall to identify factors contributing to the fall to determine the necessary course of care), dated 11/12/24, 12/22/24, and 12/25/24, the PFE indicated on: a. 11/12/24, Fall occurred in the Resident's room. Floor mat was on floor: Yes. Footwear at time of fall: Non-skid shoes/socks. b. 12/22/24, Fall occurred in the Resident's room. Activity at the time of fall: resident trying to get up from bed. Floor mat was on floor: No . Footwear at time of fall: Non-skid shoes/socks. c. 12/25/24, Fall occurred in the Resident's room. Activity at the time of fall: trying to go back to bed by hiself [sic]. Floor mat was on floor: No . Footwear at time of fall: shoes. During a review of Resident 1's Nurses Note (NN), dated 3/5/25, the NN indicated, CNA (Certified Nursing Assistant [CNA 1]) reported that a resident (Resident 1) was found on the floor. This writer (Licensed Vocational Nurse [LVN] 1) immediately went to resident room and resident was found on the floor laying on his right side. resident c/o (complained of) pain to his right hip. Notified MD (medical doctor). Received an order to send him to hospital for further evaluation and treatment. During a review of Resident 1's 5-day Investigation Summary (FIS), dated 3/10/25, the FIS indicated, On March 5, 2025 at approximately 6am, (Resident 1) was found on the floor lying on his right side near his roommate's bed. (Family Member [FM]) 1 informed Director of Nursing (DON) that (Resident 1) told (FM 1) that he wanted to go to the bathroom but when he got up from the bed, he felt dizzy and fell . (Resident 1) is a high risk for falls. Interventions such as. landing mat on the right side of the bed. have been implemented prior to this fall incident. During a review of Resident 1's PFE, dated 3/5/25, the PFE indicated, Did an injury occur as a result of the fall: Yes. Did fall result in an ER (emergency room) visit/hospitalization : Yes. Right hip. Pain score: 7 (7 - 10 indicates severe pain) . Contributing Factors. Floor mat was on floor: No . Footwear at time of fall: Bare feet. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's (Acute hospital) Orthopedic (medical specialty that focuses on the care of bones, joints, muscles, and associated structures) Consultation (OC), dated 3/6/25, the OC indicated, presents after mechanical ground-level fall (fall on the same level due to an external force or event) . Patient has a right hip intertrochanteric fracture. Need surgical fixation (process of stabilizing and joining bones or other tissues using surgical methods) . scheduled for right hip open reduction internal fixation (ORIF - surgical procedure that treats severe bone fracture or dislocation [a separation of two bones where they meet at a joint] by realigning the bones and stabilizing them with internal hardware [tools or devices used in medical procedures]) later today. During a review of Resident 1's NN, dated 3/7/25, the NN indicated, came back to (facility) from (acute hospital) . discharge diagnosis: Intertrochanteric fracture of right hip. SURGERY ORIF FEMUR (thigh bone) RIGHT HIP. During an interview on 3/13/25 at 12:42 p.m. with DON, DON was informed Resident 1 was not wearing nonskid socks at the time of fall (3/5/25). DON stated Resident 1 was supposed to wear at least nonskid socks . DON stated Resident 1's care plan for falls (to have nonskid socks, dated 10/14/24 [current care plan on 3/5/25]) was not followed. During an interview on 3/13/25 at 2:55 p.m. with LVN 1, LVN 1 stated on 3/5/25, she noted Resident 1 was lying on his right side on the floor (on the right side of the bed), with no floor mat on the right side of the bed and was bare feet. LVN 1 stated she did not know what was on Resident 1's care plan for falls. LVN 1 stated Resident 1 needed to wear nonskid socks so he would not fall. LVN 1 stated Resident 1 needed a floor mat on the right side of the bed so he won't hit his body hard on the floor and to prevent injury. During an interview on 3/18/25 at 3:56 p.m. with CNA 1, CNA 1 stated on 3/5/25, I just came in for morning shift. I never took over. I was making rounds, and I found (Resident 1) on the floor (on the right side of the bed). CNA 1 stated, There is no floor mat (on the right side of the bed). CNA 1 stated she did not know if Resident 1 was at risk for falls. CNA 1 stated, If (Resident 1) is fall risk, he is supposed to have a floor mat (on the right side of the bed) for preventing injury. During an interview on 3/21/25 at 9:18 a.m. with DON, DON stated, (Resident 1) has been falling. DON stated Resident 1 should have a floor mat on the right side of the bed to prevent injury. DON stated Resident 1's care plan (to have a floor mat on the right side of the bed, dated 10/28/24 [current care plan on 3/5/25]) for falls was not followed. During an interview on 3/24/25 on 12:53 p.m. with Nurse Consultant (NC), NC stated LVN 1, and CNA 1 should have known Resident 1 was at risk of falls and his care plan interventions for falls. NC stated the facility staff, especially nursing staff (licensed nurses and CNAs), should know the residents who are at risk for falls and their care plan interventions for falls. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled Care Planning, dated 11/1/17 (current P&P on 3/5/25), the P&P indicated, To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. The Care Plan serves as a course of action where the resident (resident's family and/or guardian or other legally authorized representative), resident's Attending Physician, and IDT (Interdisciplinary Team - group of professionals who assess, coordinate, and manage each resident's comprehensive needs) work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs.