

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055601	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2026
NAME OF PROVIDER OR SUPPLIER Parkview Julian Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**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 (P&P) on Fall Management Program, Refusal of Treatment, and Continence Management Guideline when: 1. Certified Nursing Assistant (CNA) 1 did not notify a licensed nurse when one of three sampled residents' (Resident 1) refused to have her soiled brief changed. 2. CNA 1 did not check and offer to change Resident 1's soiled brief after a refusal for one hour and 45 minutes. 3. CNA 1 did not check and offer to change Resident 1's brief every two hours. These failures had the potential to result in Resident 1 falling from trying to go to the bathroom and sustaining right distal femur (lower part of the right thigh bone) fracture (broken bone) requiring hospitalization and surgery. Findings: During a review of Resident 1's admission Record [AR], dated 1/6/26, the AR indicated, DIAGNOSIS. MUSCLE WEAKNESS (GENERALIZED). NEED FOR ASSISTANCE WITH PERSONAL CARE. HISTORY OF FALLING. DISPLACED INTERTROCHANTERIC FRACTURE [a break in the upper part of the thigh bone] OF RIGHT FEMUR [right thigh bone]. During a review of Resident 1's Minimum Data Set [MDS - an assessment tool], dated 12/4/25, the MDS indicated on section C, Resident 1 had a BIMS (Brief Interview for Mental Status) score of 3 (severe cognitive impairment - having problems with thinking abilities like memory, concentration, decision-making, and problem-solving). The MDS indicated on section GG, Resident was wheelchair-bound (unable to walk and uses a wheelchair for mobility), required total assist with toileting hygiene (ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement), and was unable to stand, walk, and transfer to the toilet. The MDS indicated on section H, Resident 1 was always incontinent to bowel and bladder (having no voluntary control over urination and defecation). During a review of Resident 1's Fall Risk Evaluation [FRE], dated 9/16/25, the FRE indicated, Resident 1 had a score of 17 (Director of Nursing [DON] stated on 1/13/26 at 9:25 a.m., score of 10 or higher indicates high fall risk). During a review of Resident 1's SBAR [Situation, Background, Assessment, Recommendation], dated 12/29/25, the SBAR indicated, Resident [1] was found with her legs off the bed and her body in the bed, [LVN 1] and CNA [1] assisted resident to the ground. [LVN 1] and CNA [1] assisted resident back to her bed where she was checked for bruising or injuries noted. Resident [1] verbalized having no pain. Resident [1] was asked what happen resident [1] stated I had to go to the restroom. Resident [1] reminded to use call light when in need of help call light is within reach and hydration. MD [Medical Doctor] and RP [Responsible Party] were notified about residents [1] recent fall. During a review of Resident 1's Care Plan [CP], dated 9/6/24 (date initiated), the CP indicated, Focus. The resident [1] is at risk for repeated falls r/t [related to] Deconditioning [decline in physical strength], Gait/balance problems, Psychoactive drug [drug that affects how the brain works] use, generalized weakness, s/p [status post] mechanical fall [a fall caused by an external factor or environmental hazard] at home resulting fx [fracture] to right femur with surgical intervention, impulsive behavior, episodes of crawling out of bed. Interventions. Anticipate and meet The resident's needs. During a</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>review of Resident 1's RADIOLOGY [medical field using imaging technologies] SERVICES PATIENT REPORT [RSPR], dated 12/29/25, the RSPR indicated, RIGHT KNEE. IMPRESSIONS: A periprosthetic fracture [a broken bone around a joint replacement] of the distal femur. The age of the fracture is indeterminate [uncertain about when the event occurred].During a concurrent interview and record review on 1/6/26 at 2:38 p.m. with DON, Resident 1's Nurses Note [NN], dated 12/31/25 was reviewed. NN indicated, Resident stated 9/10 bilateral knees and right hip pain. Observed redness on right outer thigh and swelling on right knee. MD notified and given order to Send to [acute] Hospital for CT [computed tomography scan used to take detailed images of the body] scan. DON stated on 12/29/25, Resident 1 had an x-ray (medical imaging that uses radiation to take pictures of the inside of the body) done indicating an age-indeterminate fracture. DON stated on 12/29/25, Resident 1 had no swelling on her right knee and had no pain, but on 12/31/25, Resident 1 had swelling on her right knee and complained of pain. DON stated Resident 1 was sent to the hospital on [DATE] for a CT.During a review of Resident 1's ED [Emergency Department] Physician Notes [Acute hospital records], dated 12/31/25, the ED Physician Notes indicated, pt [patient] sent from [facility] for possible CT. pt fell when trying to get out of bed on 12/29 and pt now c/o [complained of] bilateral knee pain. CT Knee Rt [right]. There is periprosthetic fracture of the distal femoral metaphysis [the flared, widened area of the thigh bone just above the knee joint] with 1 cm [centimeter - metric unit of length] impaction [the broken ends of a bone are forcefully driven into each other]. Fracture site extends to the patellofemoral compartment [compartment in the front of the knee between the knee cap and thigh bone].During a review of Resident 1's Operation/Procedure Report [OPR] [Acute hospital records], dated 1/3/26, the OPR indicated, DIAGNOSIS: Right distal femur fracture. PROCEDURES. Application of retrograde intramedullary nailing [surgery where a metal rod is inserted backward into the hollow center of a long bone to stabilize a fracture], right femur.During an interview on 1/7/26 at 1:16 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was the nurse assigned to Resident 1 when Resident 1 fell on [DATE]. LVN 1 stated on 12/29/25 around 5:15 a.m., she was passing medications when CNA 1 called her to Resident 1's room. LVN 1 stated Resident 1 had most of her hip on the bed and Resident 1's legs were hanging off the bed. LVN 1 stated she assessed Resident 1. LVN 1 stated Resident 1 did not have injuries and did not complain of pain.During an interview on 1/12/26 at 11:43 a.m. with CNA 1, CNA 1 stated she was the CNA assigned to Resident 1 when Resident 1 fell on [DATE]. CNA 1 stated on 12/29/25 at around 5:15 a.m., when she passed by Resident 1's room, CNA 1 saw Resident 1 holding the bed rail and her left leg was bent on the floor mat. CNA 1 stated Resident 1 stated she was trying to go to the bathroom to pee. CNA 1 stated she checked Resident 1's brief, and it was wet and had bowel movement. CNA 1 stated she went to see Resident 1 on 12/29/25 at 3:30 a.m. and she saw Resident 1's brief indicator color had changed from yellow to blue, indicating Resident 1's brief was wet. CNA 1 stated she offered to change Resident 1 's brief but she refused. CNA 1 stated she did not notify LVN 1 when Resident 1 refused to be changed. CNA 1 stated she did not ask help from another CNA to change Resident 1. CNA 1 stated she did not come back to ask Resident 1 to change her brief until she passed by Resident 1's room around 5:15 a.m. and saw Resident 1 falling off her bed. CNA 1 stated during her shift on 12/29/25 night shift (10 p.m. to 6:30 a.m.), she only changed Resident 1 once right after the fall at around 5:15 a.m. CNA 1 stated she did not check and change Resident 1's brief every two hours because Resident 1 would usually refuse at night, CNA 1 stated she was supposed to offer to check and change Resident 1 every two hours to prevent falls and skin breakdown. CNA 1 stated when Resident 1 refused to be changed, she should have notified LVN 1 and asked for help from the other CNAs to help her change Resident 1.During a review of the facility P&P titled, Fall Management</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Program, dated November 2017, the P&P indicated, Purpose To prevent resident falls and minimize complications associated with falls through the development of a Fall Management Program. Policy It is the policy of this facility to provide the highest quality care in the safest environment for the residents residing in the facility. Assist patient with toileting as appropriate. During a review of the facility's P&P titled, Refusal of Treatment, dated 11/1/17, the P&P indicated, When a resident refuses or discontinues treatment, the Charge Nurse or Director of Nursing Services (DNS) interviews the resident to determine what and why the resident is refusing or discontinue treatment. The Charge Nurse or DNS will attempt to address the resident's concerns and explain the consequences of the refusal or discontinuance of treatment. During a review of the facility's P&P titled, Continence Management Guideline, dated November 2017, the P&P indicated, incontinence care i. Pad/brief change every 2-4 hours.</p>		