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	04/21/2026

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 - Minimal harm or potential for 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. Based on interview and record review, the facility failed to ensure care plans were updated for one of three sampled residents (Resident 2). This failure had potential for Resident 2's care providers not to be aware of care needs.Findings:During a review of Resident 2's Therapy Post-Fall Screen, (TPFS) dated 11/3/25, the TPFS indicated, Date of Fall: 11/1/25. Comments regarding the resident's usual pattern of interaction with the environment (mobility, self-care, communication, assistance provided by caregiver: Do not leave (Resident 2) in the W/C (wheelchair) unattended Frequent monitoring of staff . floor mat call light within reach at all times.During a review of Resident 2's Therapy Post-Fall Screen, dated 3/9/26, the TPFS indicated, Date of Fall: 3/7/26. Comments regarding the resident's usual pattern of interaction with the environment (mobility, self-care, communication, assistance provided by caregiver: . floor mat frequent monitoring of staff & check vitals educate (Resident 2) about safety during transitional movement.During a concurrent interview and record review on 4/21/26 at 3:09 p.m. with Director of Nursing (DON) Resident 2's Change of Condition, dated 11/1/25 and 3/7/26 were reviewed. DON confirmed both COC were for falls and Resident 2's falls happened while in bed. Resident 2's Therapy Post-Fall Screen, dated 11/1/25 and 3/9/26 were reviewed. DON reviewed Resident 2's high risk for falls care plan and confirmed the TPFS recommendations (11/1/25 and 3/9/26) were not updated in Resident 2's care plan. DON stated we go through falls during standup; we should have caught that and on stand and updated Resident 2's high risk fall care planned.During a review of the facility's policy and procedure (P&P) titled Response to Falls, revised 11/1/17, the P&P indicated To ensure the Facility responds quickly and appropriately to resident falls in a manner that addresses both the resident's immediate needs and longer-term fall prevention. III. After each fall, a License Nurse will complete a Post-Fall Assessment & Investigation. The investigation will help to identify circumstance or factors contributing to the resident's fall. V. The Interdisiplinary Team (IDT) will review the investigative reports on a regular basis, as they may occur, and make systemic changes to reasonably limit future occurrences, consider change in POC interventions, system changes, . C. Following each resident fall, the Interdisciplinary Team (IDT)-Falls Committee will review the Post-Fall Assessment & Assessment within 72 hours, or as soon as practicable. i. Based on the Post-Fall Assessment & Investigation, the IDT-Falls Committee will review fall prevention interventions and modify the plan of care as indicated. viii. Revise resident's Care Plan as necessary.

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