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	05/06/2026

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

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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 - 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 implement Urinary Tract infection (UTI-infection in any part of the urinary system [kidneys, ureters, bladder and urethra]) care plan for one of two sampled residents (Resident 1). This failure had the potential to result in repeated UTI infection for Resident 1 and unmet care needs.Findings:During a review of Resident 1's Care Plan (CP), dated 4/13/26, the CP indicated, The resident (Resident 1) has chronic Urinary Tract Infections. Interventions. Check at least every 2 hours for incontinence (involuntary or accidental loss of bladder or bowel control). Wash, rinse and dry soiled areas. Intake (fluids that enter the body) and output (fluids that leave the body).During a concurrent interview and record review on 5/5/26 at 1:03 p.m. with Director of Nursing (DON), Resident 1's medical records (MR), undated were reviewed. The MR indicated, there was no documentation the facility was checking and providing incontinence care for Resident 1 at least every two hours. The MR indicated, there was no documentation the facility was monitoring Resident 1's urine output. DON stated if there was no documentation, it was not done. DON stated the CP was not followed.During a review of the facility's policy and procedure (P&P) titled, Care Planning, dated 11/1/17, the P&P indicated, 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, along with the resident and the family who collaborate to create and manage a personalized care plan) work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental, and psychosocial needs.

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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to ensure the IDT (Interdisciplinary Team - group of professionals, along with the resident and the family who collaborate to create and manage a personalized care plan) met to review care plans quarterly for one of two sampled residents (Resident 1). This failure had the potential to result in Resident 1's unresolved concerns and unmet care needs.Findings:During a concurrent interview and record review on 5/6/26 at 11:42 a.m. with Director of Nursing (DON), Resident 1's medical records (MR), undated were reviewed. The MR indicated, Resident 1 had a quarterly (every three months) Minimum Data Set (MDS - an assessment tool) completed on 3/6/26. The MR indicated, there was no documentation the IDT met with Resident 1 and the family to review Resident 1's care plans. DON stated the IDT should have met with Resident 1 and the family upon readmission and quarterly. DON stated there should have been a care plan meeting done on 3/6/26 for Resident 1 and the family to be informed of Resident 1's current condition, current plan of care, and to involve Resident 1 and the family in updating Resident 1's care plan based on their preferences.During a review of the facility's policy and procedure (P&P) titled, Care Planning, dated 11/1/17, the P&P indicated, 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 work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental, and psychosocial needs. The Care Plan must be completed within 7 days after completion of the Comprehensive admission Assessment, and must be periodically reviewed and revised by a team of qualified persons after each assessment, including the comprehensive and quarterly review assessments. The Care Plan must be prepared by the IDT team. The IDT team may include the following individuals: A. The Attending Physician; B. The Resident Assessment Coordinator; C. The Licensed Nurse who has responsibility of the resident; D. The Dietary Supervisor and/or registered dietician; E. Social Service staff member responsible for the resident; F. The Activity Director; G. Therapists as applicable; H. Consultants (as appropriate); I. The Director of Nursing (as applicable); J. Certified Nursing Assistants and/or RNAs responsible for the resident's care; K. The resident and/or his/her family or legal representative; i. If the resident and his/her resident representative participation is determined not practicable for the development of the resident's care plan, an explanation should be included in the resident's medical record.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure an antibiotic (medication used to treat infection) was administered as ordered by the physician for one of two sampled residents (Resident 1). This failure had the potential for Resident 1 developing sepsis (the body's extreme, life-threatening response to an infection).Findings:During a review of Resident 1's Order Listing Report (OLR), dated 5/6/26, the OLR indicated, Ertapenem (antibiotic). every 24 hours for infection for 15 days. Start Date. 4/12/26.During a concurrent interview and record review on 5/5/26 at 2:05 p.m. with Director of Nursing (DON), Resident 1's IV (Intravenous [into or within a vein]) MAR (Medication Administration Record), dated April 2026 was reviewed. The IV MAR indicated, the Ertapenem antibiotic was not administered to Resident 1 on 4/12/26 and 4/13/26. DON stated Ertapenem antibiotic should have been administered to Resident 1 within four hours of the physician's orders. DON stated if an antibiotic was not administered as scheduled, it would put Resident 1 at risk for unresolved infection and sepsis.During a review of the facility's policy and procedure (P&P) titled, Medication - Administration, dated 11/1/17, the P&P indicated, Medication will be administered by a Licensed Nurse per the order of an Attending Physician.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure fingernails were trimmed for one of three sampled residents (Resident 2) with contractures (shortening of muscles, tendons, skin, or nearby soft tissues that causes joints to become stiff and rigid) on both hands. This failure had the potential to result in Resident 2 developing skin breakdown.Findings:During a concurrent observation and interview on 5/6/26 at 9:31 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 2's room, Resident 2 had contractures on both hands and had long (approximately quarter inch) fingernails touching her palms. CNA 1 stated Resident 2 had long and sharp fingernails that can cut Resident 2's palms and could cause Resident 2 to develop skin breakdown and infection on her palms.During an interview on 5/6/26 at 11:42 a.m. with Director of Nursing (DON), DON stated Resident 2 ?s fingernails should have been trimmed, filed, and cleaned every Sunday and as needed. DON stated Resident 2's long and sharp fingernails with contractures on both hands could cause impaired skin integrity and infection.During a review of the facility's policy and procedure (P&P) titled, Grooming Care of the Fingernails and Toenails, dated 11/1/17, the P&P indicated, Nail care is given to clean and keep the nails trimmed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to provide care for midline catheter (a long, flexible, thin tube inserted into a vein in the upper arm used for delivering medications, fluids, or drawing blood samples) as ordered by the physician for one of two sampled residents (Resident 1). This failure had the potential to result in Resident 1 developing complications such as catheter blockage, infection, blood clots, and blood vessel damage.Findings:During a review of Resident 1's Order Listing Report (OLR), dated April 2026, the OLR indicated, Flush right upper arm Midline single lumen (one channel used to give one type of fluid or medication at a time) with 10 ml (milliliters [measure of volume]) saline (mixture of salt and water used for medical use) before and after IV (intravenous [into or within a vein]) medications every shift. Start Date 04/14/2026. Monitor Midline site for signs of inflammation (body's natural response to injury or infection) / (or) infiltration (fluid leaks out of the vein into surrounding soft tissue) two times a day. Start Date 04/14/2026During a concurrent interview and record review on 5/5/26 at 2:25 p.m. with Director of Nursing (DON), Resident 1's TAR (Treatment Administration Record), dated April 2026 was reviewed. The TAR indicated, there was no documentation the midline catheter site was monitored for signs of inflammation or infiltration on 4/16/26, 4/19/26, and 4/23/26 at 6:30 a.m. The TAR indicated, there was no documentation the midline catheter was flushed with 10 ml normal saline on 4/15/26 , 4/19/26, and 4/22/26 night shift (no time specified). DON stated if there was no documentation, it was not done. DON stated if the midline catheter site was not monitored as ordered by the physician, it would put Resident 1 at risk for phlebitis (inflammation of a vein), infiltration, blood clots, and damage to the nerves. DON stated if the midline catheter was not flushed as ordered by the physician, it would put Resident 1's midline catheter at risk for clogging resulting in Resident 1 not getting her medication.During a review of the facility's policy and procedure (P&P) titled, CARE OF PERIPHERAL INSERTERD CENTRAL LINES (PICC) - DRESING CHANGE AND SITE CARE, undated, the P&P indicated, Purpose. To minimize the possibility of local and systemic infection. Verify physician's order. Assess the insertion site, areas and the course of the vein for redness, tenderness, edema, and drainage.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure treatments were done as ordered by the physician for one of three sampled residents (Resident 2). This failure had the potential to result in Resident 2 developing further skin breakdown.Findings:During a review of Resident 2's Order Summary Report (OSR), dated 5/6/26, the OSR indicated, Apply skin barrier (thick cream used to protect skin from moisture damage) to coccyx (tailbone) every shift for Skin Maintenance. Calmoseptine (thick ointment used to treat and prevent skin irritation, rashes, and itching) . Apply to affected areas (unspecified) topically (applying a medication directly to a specific spot on the outside of the body) two times a day for skin maintenance. Cleanse with Normal Saline (mixture of salt and water used for medical use). Pat dry. Apply Betadine (medication used on the skin to treat and prevent infections) to periwound (skin and tissue surrounding a wound) maceration (softening and breaking down of skin caused by prolonged exposure to moisture), apply calcium ag (calcium alginate [used to treat wounds]) to wound bed and cover with dry dressing (absorbent bandage applied to a wound to keep it clean and dry). Change dressing daily and PRN (as needed) for loss of integrity/soiling every day shift for (left heel) Stage 3 PI (pressure injury [damaged skin and tissue caused by prolonged, uninterrupted pressure on a specific area]).During a concurrent interview and record review on 5/5/26 at 2:55 p.m. with Director of Nursing (DON), Resident 2's TAR (Treatment Administration Record), dated April 2026 was reviewed. The TAR indicated, there was no documentation skin barrier was applied to Resident 2's coccyx on 4/4/26 and 4/11/26. The TAR indicated, there was no documentation Calmoseptine was applied to Resident 2's affected areas (unspecified) on 4/4/26 at 9 a.m., 4/11/26 at 9 a.m., 4/23/26 at 5 p.m., and 4/26/26 at 9 a.m. The TAR indicated, there was no documentation treatment was done for Resident 2's left heel stage three pressure injury (tissue damage that results in full-thickness loss of skin and the layer of fat under the skin may be visible) on 4/4/26, 4/11/26, 4/26/26. DON stated if there was no documentation, the treatment was not done. DON stated, if the skin barrier was not applied to Resident 2's coccyx as ordered by the physician, it would put Resident 2 at risk for pressure injury. DON stated, if Calmoseptine was not applied to Resident 2's affected areas (unspecified) as ordered by the physician, it would put Resident 2 at risk for MASD (moisture-associated skin damage [skin irritation, inflammation, or breakdown caused by long-term exposure to moisture]). DON stated if the treatment for Resident 2's left heel stage three pressure injury was not done as ordered by the physician, Resident 2 could re-develop a stage four pressure injury (severe, deep, and open crater that has destroyed all layers of skin, exposing underlying muscle, tendon, or bone) on her left heel.During a review of the facility's policy and procedure (P&P) titled, Wound Management, dated 11/1/17, the P&P indicated, A resident who has a wound will receive necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing. the nurse will. Implement a wound treatment per physician's orders.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to follow its own policy and procedure (P&P) when interventions to manage contractures (shortening of muscles, tendons, skin, or nearby soft tissues that causes joints to become stiff and rigid) was not provided on both hands for one of three sampled residents (Resident 2). This failure had the potential to result in Resident 2 developing worsened contractures.Findings:During a concurrent observation and interview on 5/6/26 at 9:31 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 2's room, Resident 2 had contractures on both hands, and did not have a device on both hands to manage her contractures. CNA 1 stated she was not sure if Resident 2 was supposed to have a device on both hands to manage her contractures.During a concurrent interview and record review on 5/6/26 at 11:42 a.m. with Director of Nursing (DON), Resident 2's medical records (MR), undated were reviewed. The MR indicated, there was no intervention to manage Resident 2's contractures on both hands. DON stated Resident 2 should have had hand rolls (soft, rolled-up device placed inside the palm to prevent fingers from curling into a tight fist) on both hands to prevent contractures, to restore muscle movement, and to protect Resident 2's skin.During a review of the facility's policy and procedure (P&P) titled, Contracture Prevention, dated 11/1/17, the P&P indicated, The Facility Implements interventions to prevent the onset of contractures and to prevent worsening of contractures for residents admitted with contractures.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure a GT (Gastric Tube - tube inserted through the stomach to deliver food, liquids, and medication) site was covered with a T-drain dressing (specialized absorbent bandage to protect skin) as ordered by the physician for one of two sampled residents (Resident 2). This failure had the potential to result in Resident 2 developing skin irritation and infection.Findings:During a review of Resident 2's Order Summary Report (OSR), dated 5/6/26, the OSR indicated, Cleanse GT site to abdomen with normal saline (mixture of salt and water used for medical use), pat dry, apply T-drain daily.During a concurrent observation and interview on 5/6/26 at 9:55 a.m. with Treatment Nurse (TN) in Resident 2's room, Resident 2's GT site was not covered with a T-drain dressing. TN stated, It (GT site) needs a dressing. TN stated she did not know Resident 2's GT site did not have a dressing. TN stated Resident 2's GT site's T-drain dressing was supposed to be changed daily and as needed. TN stated Resident 2's GT site should be covered with a T-drain dressing to ensure the GT site was clean and to prevent infection.During an interview on 5/6/26 at 10:03 a.m. with Director of Nursing (DON), DON stated Resident 2's GT site was supposed to be covered to protect the skin and to prevent infection.During a review of the facility's policy and procedure (P&P) titled, Feeding Tube - Site Care, dated 11/1/17, the P&P indicated, Purpose To inspect and prevent skin breakdown and complications for residents with feeding tubes. Place a gauze drainage sponge around the site.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&P) on Resident Isolation - Categories of Transmission-Based Precautions when proper PPEs (personal protective equipment) were not worn and proper resident cohorting (to group individuals who have the same infection together) was not done for one of two sampled residents (Resident 3). These failures had the potential to result in the spread of germs in the facility.Findings:During a review of Resident 3's Order Summary Report (OSR), dated 5/6/26, the OSR indicated, CONTACT ISOLATION***R/T (related to) MRSA (Methicillin-resistant Staphylococcus aureus [type of bacteria that causes infections resistant to many common antibiotics]).During an observation on 5/5/26 at 10:31 a.m. outside Resident 3's room, a contact isolation sign (CIS) was posted on Resident 3's door. The sign indicated, CONTACT ISOLATION Prior to entering the room. CLEAN HANDS. GOWN. GLOVES. Resident 3 was cohorted with another resident without isolation precautions. Certified Nursing Assistant (CNA) 2 entered Resident 3's room without wearing a gown and gloves.During an interview on 5/5/26 at 10:31 a.m. with CNA 2, CNA 2 stated she was aware Resident 3 was on contact precautions. CNA 2 stated she did not wear a gown and gloves prior to entering Resident 3's room. CNA 2 stated she should have worn a gown and gloves according to the CIS on Resident 3's door.During a concurrent interview and record review on 5/6/26 at 3:10 p.m. with Director of Nursing (DON), the facility's CIS, dated 4/2/25 was reviewed. The CIS indicated, CONTACT ISOLATION Prior to entering the room. CLEAN HANDS. GOWN. GLOVES. DON stated when CNA 2 entered Resident 3's room without wearing a gown and gloves, the CIS was not followed, and the CIS should have been followed.During a concurrent interview and record review on 5/6/26 at 3:38 p.m. with the Infection Preventionist (IP), the facility's P&P titled, Resident Isolation - Categories of Transmission-Based Precautions, dated 11/1/17 was reviewed. The P&P indicated, Contact Precautions. The resident is placed in a private room when it is not feasible to contain drainage, excretions, blood or body fluids. When a private room is not available, the Infection Control Coordinator assesses various risks associated with other resident placement (e.g., cohorting) . gloves (clean, non-sterile) are worn when entering the room. a (clean, non-sterile) gown is worn for interactions that may involve contact with the resident or potentially contaminated items in the resident's environment. IP stated Resident 3 was on contact precautions. IP stated Resident 3 was in a room with another resident without isolation precautions. IP stated the P&P was not followed.