

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/18/2025
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)		
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observation, interview and record review, the facility failed to ensure three of four sampled residents (Resident 1, Resident 30 and Resident 75) had comprehensive activities assessments and activities care plans developed specific to the preferences and interests of Resident 1, Resident 30 and Resident 75. This failure resulted in Resident 1, Resident 30 and Resident 75 not receiving activities specific to their preference or interests. This failure resulted in a decreased quality of life for Resident 1, Resident 30, and Resident 75. Findings: a. During an observation on 12/17/25 at 2:23 p.m. outside of Resident 1's room, activities staff (AS) was pushing a cart to resident rooms. AS visited multiple resident's rooms but did not attempt to enter Resident 1's room. During an interview on 12/18/25 at 8:45 a.m. with AS, AS stated she assumed Resident 1's son was in the room visiting the day before (12/17/25) and did not go in Resident 1's room. AS stated she does not go into Resident 1's room normally, because Resident 1 refuses activities. During a concurrent interview and record review on 12/18/25 at 8:57 a.m. with Activities Director (AD), Resident 1's [Facility Name] Quality of life Initial Assessment (QOLA - comprehensive activities assessments), dated 7/31/25 was reviewed. The QOLA indicated Resident 1 spent time at home cooking and cleaning but did not include any personal interests. AD stated activities staff should still check on and offer activities to Resident 1 each day. During a concurrent interview and records review on 12/18/25 at 9:01 a.m. with AD, Resident 1's Care Plan (CP), dated 7/31/25 was reviewed. The CP indicated, The resident [Resident 1] needs 1:1 bedside/in-room visits and activities if unable to attend out of room events. AD stated the CP did not include personalized interests for Resident 1. b. During an interview on 12/17/25 at 1:27 p.m. with Resident 30, Resident 30 stated he was unable to get out of bed and attend activities. Resident 30 stated he used to be an avid reader but could not see well enough to read anymore. Resident 30 stated he would be interested in audio books but did not have access to any. Resident 30 stated he watched television (tv) most of the time but has difficulty seeing because the tv was so small and so far away. Resident 30 stated he had asked for a bigger tv but the facility had not provided one. During an observation on 12/17/25 at 2:16 p.m. AS was in Resident 30's room. AS told Resident 1 she would leave the Daily Chronicle (flyer with facility information and news) for him. Resident 1 responded to AS stating he was unable to read it since his eye sight was so bad. Resident 30 told AS he would like to have a bigger tv. AS responded to Resident 1 by laughing and teasing Resident 1 stating, What do you want an 85 inch big screen? During a concurrent interview and record review on 12/18/25 at 9:11 a.m. with AD, Resident 30's QOLA, dated 10/23/25 was reviewed. The QOLA indicated having books, newspapers and magazines to read was somewhat important but did not indicate what type of books, newspapers or magazines. The QOLA indicated listening to music he liked was very important to Resident 30 but did not indicate what type of music. The QOLA indicated doing his favorite activities was somewhat important to Resident 3 but did not indicate what specific activities. The QOLA indicated going outside and getting fresh air when the weather was good was very important to Resident 3 but did not indicate how the facility would accommodate his preference. AD stated the QOLA was not specific to the personal interests of Resident 30. During a concurrent interview and record review on 12/18/25 at 9:16 a.m. with AD, Resident 30's CP, dated 10/15/25 was reviewed. The CP indicated, The resident [Resident 30] needs a variety of activity types and (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: 055601	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
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)		
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	locations to maintain interests. AD stated the CP was not specific to the personal interests of Resident 30. c. During an concurrent observation and interview on 12/17/25 at 2:06 p.m. with AS, AS entered Resident 75's room and left an iPad on the bedside table. AS stated the iPad was providing musical sensory activity for Resident 75. During a concurrent interview and record review on 12/18/25 at 9:03 a.m. with AD, Resident 75's QOLA, dated 11/18/25 was reviewed. The QOLA indicated unknown for demographic information (including birthplace, culture, pets, and occupations) and no response to activity preferences (including reading books, newspapers, magazines, listening to music, favorite activities and going outside). The QOLA indicated, Activity staff will provide room visits daily with sensory activities. AD stated Resident 75's QOLA was incomplete. AD stated she had attempted to contact Resident 75's family but was unable to provide documentation that attempt was made to contact a family member. During a concurrent interview and record review on 12/18/25 at 9:09 a.m. with AD, Resident 75's CP, dated 11/18/25 was reviewed. The CP indicated, The resident [Resident 75] needs 1:1 bedside/in-room visits and activities if unable to attend out of room events. AD stated Resident 75's CP was not specific to his personalized preferences for activities. During a review of the facility's policy and procedure (P&P) titled, Activities Program, dated 4/1/21, the P&P indicated, To encourage residents to participate in activities to make life more meaningful, to stimulate and support physical and mental capabilities to the fullest extent, and to enable the resident to maintain the highest attainable social, physical and emotional functioning. I. The Facility provides an Activity Program designed to meet the needs, interests, and preferences of residents. The activities are varied to address the needs and interests identified through the assessment process. The Activity Program will address areas including, but not limited to: A. Social activities; B. Indoor and outdoor activities; C. Activities away from the Facility; D. Religious programs; E. Opportunity for resident involvement for planning activities; F Creative activities; Educational activities; and H. Exercise activities. II. A variety of activities are offered on a daily basis, which includes weekends and evenings. III. Activities are developed for individual, small group, and large group participation. Procedure I. Assessment. B. The initial Activity Assessment [QOLA] is completed by the Director of Activities, or his or her designee, withing seven (7) days of admission. The Director of Activities, or his or her designee, will conduct an interview with the resident or gather information to complete the Staff Assessment. II. Care Plan A. After completion of the initial Activity Assessment. an individualized Care Plan will be developed and implemented for each resident. D. As needed, activities are tailored to meet the needs of resident with cognitive impairment or other special needs.		

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 12/18/2025
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure professional standards for food service safety and sanitary kitchen conditions were followed when: 1. Two opened boxes of vegetables in the refrigerator in the dry storage room were not labeled with a received, opened and use by date. This had the potential for residents to be served unpalatable food.2. An opened unlabeled box of butter was stored in one of one refrigerator in the dry storage room. This had the potential for residents to be served unpalatable food.3. Food scoops were stored inside two of four dry good food containers. This failure had the potential to cause foodborne illnesses (illness caused by the ingestion of contaminated food) for residents.4. One of one sampled ice cream scoop was not cleaned prior to being stored with clean utensils. This failure had the potential to cause foodborne illnesses (illness caused by the ingestion of contaminated food) for residents.5. Two rolls of unlabeled meat were stored in one of one of the freezers in the hallway outside the kitchen. This had the potential for residents to be served unpalatable food.This failure had the potential to cause foodborne illnesses (illness caused by the ingestion of contaminated food) for residents.Findings:1. During a concurrent observation and interview on 12/15/25 at 7:50 a.m. with Dietary Service Supervisor (DSS), in the dry storage room, an opened box of carrots was in the refrigerator. The box of carrots was not labeled with a received, opened, and used by date. DSS stated the box of carrots should have been labeled with the received, opened, and used by date.During a concurrent observation and interview on 12/15/25 at 7:50 a.m. with Dietary Service Supervisor (DSS), in the dry storage room, an opened box of lettuce was in the refrigerator. The box of lettuce was not labeled with a received, opened, and used by date. DSS stated the box of lettuce should have been labeled with the received, opened, and used by date.2. During a concurrent observation and interview on 12/15/25 at 7:50 a.m. with Dietary Service Supervisor (DSS), in the dry storage room, an opened box of butter was in the refrigerator. The box of butter was not labeled with a received, opened, and used by date. DSS stated the box of butter should have been labeled with the received, opened, and used by date.During a review of the facility's Policy and Procedure (P&P) titled, Labeling and dating of foods, dated 2023, the P&P indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated.Food delivered needs to be marked with a received date. Note that the delivery sticker is dated, and it can serve as the date for product. Newly opened food items will need to be closed and labeled with an open date and used by date.Produce is to be dated with received date. 3. During a concurrent observation and interview on 12/15/25 at 8:09 a.m. in the kitchen with the facility cook, the food scoop was stored inside the dry flour bin. The scoop was touching the flour and was not stored separately outside the flour bin. [NAME] stated the scoop should be stored separately from the food bin.4. During a concurrent observation and interview on 12/15/25 at 8:11 a.m. in the kitchen with Cook, the food scoop was stored inside the dry oatmeal bin. The scoop was touching the oatmeal and was not stored separately from the oatmeal bin. [NAME] stated the scoop should be stored separately from the food bin.During a review of the P&P titled, Ingredient Bins, dated 2023, the P&P indicated, Scoops used in bins must not be left in the bin. If scoops are used, they are to be kept in a protected container/cover, conveniently located near the bins.5. During a concurrent observation and interview on 12/15/25 at 8:15 a.m. in the kitchen with the Certified Dietary Manager (CDM), an ice cream scoop with food particles and debris was stored in the clean kitchen utensils drawer. CDM stated the scoop was not cleaned properly and it should not have been stored with the clean utensils.During a review of the P&P titled, Dishwashing, dated 2023, the P&P indicated, Gross food particles shall be removed by careful scraping and pre-rinsing in running water. During a concurrent observation and interview on 12/15/25 at 8:29 a.m. in the hallway next to the kitchen with CDM, in the freezer located in the hallway next to the kitchen there were two unlabeled white rolls of frozen meat. CDM stated the meat was ground beef, but it was not labeled and stated the package should (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/18/2025
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have been labeled. During a review of the facility's Policy and Procedure (P&P) titled, Labeling and dating of foods, dated 2023, the P&P indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated. Food delivered needs to be marked with a received date. Note that the delivery sticker is dated, and it can serve as the date for product. Newly opened food items will need to be closed and labeled with an open date and used by date. Produce is to be dated with received date.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/18/2025
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)		
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to follow its policy and procedure (P&P) titled Miscellaneous Areas when one of three trash bins could not be closed. This failure had the potential to attract flies, vermin, and rodents that carry diseases which could infect the residents and cause an infestation in the facility. Findings: During a concurrent observation and interview on 12/15/25 at 8:25 a.m. with Certified Dietary Manager (CDM) in the outside area where the trash bins are located. One of three trash bins had the lid open, and the trash bags were overflowing from the top of the bin. CDM stated the staff should have put the trash in the trash bin that was empty. CDM stated staff know that they must be able to close the lid, to prevent attracting flies or rodents. During a review of the facility P&P titled, Miscellaneous Areas, dated 2023, the P&P indicated, Garbage and trashcans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed. The trash collection area is a potential feeding ground for vermin and rodents. Fly and Vermin Control Flies are carriers of disease and are a constant enemy of high standards of sanitation in the Food & Nutrition Services Department.		

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 12/18/2025
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure sanitary disposal of three used trash bags. This failure had the potential to result in the spread of infection to residents, staff, and visitors. During an observation on 12/15/25 at 8:38 a.m., in room [ROOM NUMBER]'s bathroom, a plastic trash bag containing trash was on the floor next to a trash can inside the resident's bathroom. During a concurrent observation and interview with Licensed Vocational Nurse (LVN) 2, in Resident 30's bathroom, trash was on the floor. LVN 2 stated, the certified nurse assistant should have placed the bag in the trash can, it should not be there on the floor. During an observation on 12/15/25, at 10 a.m., in Resident 52's room, looking out onto the patio area outside, a clear plastic bag was seen on the ground across the courtyard in the resident's patio area. The plastic trash bag contained a brown substance. During a concurrent observation and interview on 12/15/25 at 10:10 a.m., with Transportation/Help and Maintenance Supervisor (MS), Transportation/Help put on gloves and opened the plastic trash bag that was seen on the patio form Resident 52's room. Transportation/Help stated, it's poop [feces]. MS stated he was not sure how the trash bag got on there. During an interview with the Administrator on 12/16/25, at 8:28 a.m., the Administrator stated the outdoor patio area located between the resident rooms on C wing and resident rooms on B wing. Resident and their families can use the patio areas located outside of those rooms. During a concurrent observation and interview on 12/17/25, at 9: 10 AM, with Director of Staff Development (DSD), Infection Preventionist (IP), and Laundry Staff (LS), in the laundry room plastic bags were stored on the floor next to the washer. IP put on gloves and lifted the top plastic trash bag, underneath was a second trash bag. IP opened the trash bag. The first bag contained used mopheads, and the second trash bag contained used dirty towel. LS stated the bags of trash should not have been stored on the floor. A facility policy and procedure was requested, none was provided.		

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 12/18/2025
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)		
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 observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan (CP) for one of six sampled residents (Resident 89). This failure had the potential to result in Resident 89 having an unrecognized change in condition and adverse health outcome. Findings: During an observation on 12/16/25 at 8:58 a.m. with Resident 89, in Resident 89's room. Resident 89 was receiving oxygen through a nasal cannula (A lightweight tubing device that is placed in the patient's nose to deliver supplemental oxygen). During a review of Resident 89's Clinical Record (CR), the CR indicated Resident 89 had a Physician Order (PO) for Oxygen-continuously to start at 5 LPM (liters per minute) via nasal cannula to maintain Oxygen [O2] sat [saturation - level of O2 in the blood] above 92% [percent] notify MD [Medical Doctor] if O2 drops below 92 %. During a concurrent interview and record review on 12/18/25 at 10:15 a.m. with Minimum Data Set Coordinator (MDSC), Resident 89's Care Plan (CP), was reviewed. MDSC stated Resident 89 was receiving oxygen via nasal cannula and stated no care plan for oxygen was found in Resident 89's medical record. MDSC stated there should have been a care plan for oxygen. During a review of the facility's policy and procedure (P&P) titled, Care Planning, dated 2017, the P&P indicated, A comprehensive person-centered care plan will be developed for each resident. The care plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychological needs. Each resident's care plan will describe the following: A. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.		

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 12/18/2025
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)		
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 ensure one of three sampled residents (Resident 75) was provided quality health care when: a. Resident 75's laboratory results were not reviewed and reported to the physician in a timely manner. This failure had the potential to result in delayed treatment and worsening of Resident 75's infection. b. Interdisciplinary Team (IDT - a group of health care providers) did not develop an individualized care plan (CP) for Resident 75's contact isolation (CI - infection control process for preventing germs from spreading through direct touch or contaminated surfaces). This failure resulted in staff not being aware of Resident 75's infection and the potential for the infect to spread to staff and other residents in the facility. c. Resident 75 was kept on contact isolation for 13 days after the physician order for contact isolation was discontinued. This failure resulted in unnecessary isolation had the potential to result in emotional distress for Resident 75. Findings: a. During a concurrent interview and record review on 12/18/25 at 2:54 p.m. with IP, Resident 75's Lab Results Report (LRR), dated 12/1/25 was reviewed. The LRR indicated multiple abnormal lab results. IP stated the LRR was received by the facility on 12/1/25. During a concurrent interview and record review on 12/18/25 at 2:56 p.m. with IP, Resident 75's Progress Notes (PN), dated 12/4/25 was reviewed. The PN indicated the physician was notified of the abnormal lab results on 12/4/25. IP stated the lab results needed to be reported to the physician on 12/1/25 when the facility received them. During a concurrent interview and record review on 12/18/25 at 3:30 p.m. with DON, Resident 75's medical record was reviewed. DON stated lab results were to be reviewed and reported to the physician as soon as possible. DON stated Resident 75's results were received on 12/1/25 and reported to the physician on 12/4/25 (three days later). DON stated the review and physician notification was not timely and care of Resident 75 was delayed. b. During a concurrent interview and observation on 12/15/25 at 8:39 a.m. with Housekeeper (HK), outside of Resident 75's room, a contact isolation sign was posted on the wall beside the door. Resident 75 was the only resident in the room. HK stated Resident 75 was on contact isolation but did not know what type of infection. During a concurrent interview and record review on 12/16/25 at 11:46 a.m. with Registered Nurse (RN), Resident 75's Physician Order (PO), dated 11/17/25 was reviewed. The PO indicated, Patient on Contact Isolation for ESBL [infection caused by bacteria that produce enzymes, Extended-Spectrum Beta-Lactamases (ESBL), which break down many antibiotics, making infections harder to treat.] in the urine. RN stated she did not know what type of infection Resident 75 and needed to review his medical record. RN stated Resident 75 was placed on contact isolation on 11/17/25. During a concurrent interview and record review on 12/16/25 at 11:48 a.m. with RN, Resident 75's PO, dated 11/14/25 was reviewed. The PO indicated, Meropenem [antibiotic used to treat serious bacterial infections] 1 GM [gram]. two times a day for ESBL UTI [urinary tract infection] for 2 weeks. RN stated the antibiotic treatment was completed on 11/29/25. RN stated there were no current orders for antibiotic treatment. RN stated she was not sure why Resident 75 was still on contact isolation. During a concurrent interview and observation on 12/17/25 at 8:32 a.m. with Licensed Vocational Nurse (LVN) 1, outside of Resident 75's room, a contact isolation sign was on the wall by the door. LVN 1 stated she did not know why Resident 75 was on contact isolation and could not identify the type of infection Resident 75 had. During a concurrent interview and record review on 12/18/25 at 12:17 p.m. with Minimum Data Set Coordinator (MDSC), Resident 75's CP, was reviewed. The CP did not indicate a care plan for Resident 75's contact isolation and infection. MDSC stated there was no CP for Resident 75's contact isolation and infection. During a concurrent interview and record review on 12/18/25 at 3:49 p.m. with DON, Resident 75's IDT Notes (IDT), dated 11/14/25 through 12/18/25 were reviewed. DON stated there were no IDT notes for Resident 75. DON stated it was the responsibility of the IDT to develop and implement care plans for each resident. c. During a concurrent interview and record review on 12/17/25 at 8:34 a.m. with Director of Nursing (DON), Resident 75's PO, dated 11/14/25 was reviewed. The PO indicated Resident 75 had completed (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/18/2025
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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his antibiotic treatment on 11/29/25. DON stated after antibiotic treatment was completed the resident would stay on contact isolation for three additional days to be sure the infection was gone. DON stated Resident 75 had not been taken off contact isolation. DON stated the IDT team was responsible for review of residents on isolation and antibiotics but had not reviewed Resident 75. During a concurrent interview and record review on 12/18/25 at 2:50 p.m. with Infection Prevention Nurse (IP), Resident 75's PO's were reviewed. The PO indicated Resident 75's order for contact isolation was discontinued on 12/4/25. IP stated the contact isolation sign outside of Resident 75's room should have been removed on 12/4/25. During a review of the facility's policy and procedure (P&P) titled, Care Planning, dated 11/1/17, the P&P indicated, I. The Facility's Interdisciplinary Team (IDT) will develop a Comprehensive Care Plan for each resident. II. 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, family and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/18/2025
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)		
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure annual competencies were completed for one of six sampled employees (Certified Nursing Assistant [CNA] 1) was completed. This failure had the potential for the staff not be aware of their need for improvement in certain areas, which could affect resident care. During a concurrent interview and record on 12/18/25 at 10:48 a.m. with Director of Staff Development (DSD), Certified Nursing Assistant (CNA) 1's personal file (PF), [undated] was reviewed. The PF indicated CNA 1 was hired on 6/5/24. The PF indicated there was no annual competency completed for CNA 1. DSD stated there should have been annual competency done in June of 2025 but there was none completed. During a review of the facility's P&P titled, Care Standards, dated 11/1/17, the P&P indicated, V. The DNS or designee evaluates staff competency in skills and techniques necessary to care for residents assessed needs.		

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 12/18/2025
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)		
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure patio area located between Station B and Station C was maintained in a clean and sanitary manner. This failure had the potential to result in the spread of infection to residents, staff and visitors. During an interview on 12/15/25 at 10 a.m. with Resident 52, in Resident 52's room. Resident 52 stated he would like to have a cover or umbrella on the patio area to sit with family or children who visit on the patio area outside his room. During an observation on 12/15/25, at 10:02 a.m. in Resident 52's room, on to the patio area, a plastic bag was on the ground across the courtyard in the resident's patio area. The plastic trash bag contained a brown substance. During a concurrent observation and interview on 12/15/25 at 10:10 a.m., with Transportation/Help and Maintenance Supervisor (MS), Transportation/Help put on gloves and open the plastic trash bag, Transportation/Help stated, it's poop [feces - human waste product]. MS stated he was not sure how the trash bag got there. During an interview with the Administrator on 12/16/25, at 8:28 a.m., the Administrator stated the outdoor patio area located between the resident rooms on C wing (location of room [ROOM NUMBER]) and resident rooms on B wing can use the patio areas located outside of those rooms. Residents could exit outside to the patio area with their families. During a concurrent observation and interview on 12/17/25, at 9: 10 AM, with Director of Staff Development, Infection Preventionist (IP), and Laundry Staff (LS), plastic bags were seen on the floor next to the washer. IP put on gloves and lifted the plastic trash bag, underneath was a second trash bag which contained used dirty towels, the first bag contained used mopheads. LS stated the bags of trash should not have been stored on the floor. A facility policy and procedure was requested, none was provided.		