STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056294	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Joaquin Nursing Center and Rehabilitation Cent	3601 San Dimas Bakersfield, CA 93301

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 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on interview and record review, the hospital failed to follow its policy and procedure (P&P) titled, Background Screening Investigations when one of three sampled Licensed Vocational Nurse (LVN) 1's background check was not completed within two days prior to employment. This failure had the potential to expose residents to staff with criminal background. Findings: During a concurrent interview and record review on 4/1/25 at 3:18 p.m. with Director Staff Development (DSD), LVN 1's Employee File (EF) was reviewed. The EF indicated LVN 1's hire date was 2/6/23 and LVN 1's background check was completed on 3/18/23 (one month and six days later). DSD stated the background check was completed after the hire date and background checks should be completed before hire date. During a review of the facility's P&P titled, Background Screening Investigations, dated 3/2019, the P&P indicated, The director of personnel, or designee, conducts background checks, reference checks and criminal conviction checks (including fingerprinting as may be required by state law) on all potential direct access employees and contractors. Background and criminal checks are initiated within two days of an offer of employment or contract agreement and completed prior to employment.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure: 1. Wound treatments were completed as ordered by the physician for three of three sampled residents (Resident 1, Resident 2, and Resident 3). 2. Weekly wound assessments were completed for two of three sampled residents (Resident 2 and Resident 3). These failures had the potential for delayed wound healing, worsening of wounds, and infection for Resident 1, Resident 2, and Resident 3. Findings: 1. a) During a review of Resident 1's Order Summary Report (OSR), dated 3/17/25, the OSR indicated, Cleanse Wounds to R [right] upper arm, R Forearm [the part of the arm between the elbow and the wrist] and R hand with Dakins [a diluted solution, often used for wound care]. then cut holes for suction and turn wound vac [vacuum] on Q [every] Mon [Monday], Wed [Wednesday], Fri [Friday] & [and] PRN [as needed]. start date 3/17/25. During a concurrent interview and record review on 4/1/25 at 2:39 p.m. with Director of Staff Development (DSD), Resident 1's Treatment Administration Record (TAR), dated 3/2025 was reviewed. The TAR indicated the wound treatments were not completed on 3/28/25 and 3/31/25. DSD stated Resident 1's TAR was blank for all wounds on 3/28/25 and 3/31/25 indicating wound treatments were not performed. b) During a review of Resident 2's OSR, dated 3/17/25, the OSR indicated, Medihoney [wound treatment medication] Wound/Burn Dressing External Gel (wound dressing): Apply to L [left] iliac Crest [bone in the pelvis] topically every day shift for Stage III [involves full-thickness skin loss] pressure injury for 21 days . start date 3/13/25. Medihoney Wound/Burn Dressing External Gel: Apply to R Gluteus [buttocks] topically every day shift for Stage II [open wound with a red or pink wound bed] pressure injury for 21 days . start date 3/13/25. Medihoney Wound/Burn Dressing External Gel: Apply to R Iliac Crest [pelvis] topically every day shift for Stage III [full-thickness skin loss, meaning the injury extends through the skin into deeper tissue and fat] pressure injury for 21 days . start date 3/13/25. During a concurrent interview and record review on 4/1/25 at 1:50 p.m. with DSD, Resident 2's TAR, dated 3/2025 was reviewed. The TAR indicated the wound treatments were not completed on 3/15/25, 3/16/25, 3/28/25, 3/29/25 and 3/30/25. DSD stated Resident 2's TAR was blank for all wounds on 3/15/25, 3/16/25, 3/28/25, 3/29/25 and 3/30/25 which indicated wound treatments were not performed. c) During a review of Resident 3's OSR, dated 2/20/25, the OSR indicated, Betadine [a solution to help clean wounds] External Solution 10% Apply to L Lateral [side] Heel topically every day shift for Fluid Filled Blister for 21 days. start date 2/21/25. Medihoney Wound/Burn Dressing External Gel (wound dressings) Apply to L Ischium [bone in the pelvis] topically every day shift for stage III pressure injury for 21 days. start date: 2/21/25. Medihoney Wound/Burn Dressing External Gel (wound dressing) apply to R medial [middle] thigh topically every day shift for stage III pressure injury for 21 days. stat date: 2/21/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/1/25 at 2:13 p.m. with DSD, Resident 3's TAR, dated 2/2025 was reviewed. The TAR indicated the wound treatment was not completed on 2/22/25. DSD stated Resident 3's TAR was blank for the wound treatment on 2/22/25 which means the wound treatment was not performed on 2/22/25. During a concurrent interview and record review on 4/1/25 at 2:13 p.m. with DSD, Resident 3's TAR, dated 3/2025 was reviewed. The TAR indicated the wound treatments were not completed on the left heel on 3/28/25 and 3/131/25. The TAR indicated wound care were not completed for R [right] medial [middle] thigh & L [left] ischium [hip] from 3/14/25 through 3/31/25. DSD stated Resident 3's TAR was blank on 3/14/25 through 3/31/25 which means wound care was not performed. During an interview on 4/1/25 at 3:48 p.m. with Director of Nursing (DON), DON stated the expectation is for staff to sign the TAR when wound treatment is completed. During an interview on 4/29/25 at 10:14 a.m. with DON, DON stated when the wound nurse is not scheduled to work, the nurse on the floor is responsible to complete the wound treatment and if the wound treatment was not documented then the wound treatment was not completed. 2. a) During a concurrent interview and record review on 4/1/25 at 1:50 p.m. with DSD, Resident 2's Skin & Wound Evaluation (SWE) dated 3/19/25 was reviewed. The SWE indicated there were no wound measurements for left iliac crest wound on 3/19/25. DSD stated there are no wound measurements and the rest of the assessment is blank. DSD stated, This is not a complete assessment. During an interview on 4/1/25 at 1:50 p.m. with DSD, DSD stated Resident 2's SWE, dated 3/19/25 for R Gluteus was missing. DSD stated there should have been a wound assessment on the R Gluteus. During a concurrent interview and record review on 4/1/25 at 1:50 p.m. with DSD, Resident 2's SWE dated 3/27/25 was reviewed. The SWE indicated there were no wound measurements on 3/27/25 on the R Iliac Crest. DSD stated, This is not a complete assessment. During a concurrent interview and record review on 4/1/25 at 2:13 p.m. with DSD, Resident 2's SWE dated 3/27/25 was reviewed. The SWE indicated the wound assessment for R Gluteus (buttock muscle) on 3/27/25 was left blank. DSD stated, This is not a complete assessment because the fields are missing responses. b) During a concurrent interview and record review on 4/1/25 at 2:13 p.m. with DSD, Resident 3's Admission/readmission Evaluation/Assessment (AA), dated 2/20/25, indicated for L [left] medial proximal [near the center of the body] calf venous [vein] stasis [lack of movement] ulcer, L medial distal [further away] calf venous stasis, L lateral heal fluid filled blister, L ischium stage III pressure injury, and R medial thigh stage III pressure injury was reviewed. The AA indicated there were no wound measurements completed on all of the five wounds on 2/20/25, . DSD stated, There are no measurements for the wounds upon admission which means these are incomplete assessments. During a concurrent interview and record review on 4/1/25 at 2:13 p.m. with DSD, Resident 3's SWE dated 2/26/25 was reviewed. The SWE indicated the assessment was partially completed on 2/26/25 for L medial calf (back of the shin) distal (farther area). DSD stated, The only part of the assessment that is complete are wound measurements everything else is left blank and not a complete assessment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/1/25 at 2:13 p.m. with DSD, DSD stated there are no weekly wound assessments of the L medial proximal calf venous stasis ulcer, L medial distal calf venous stasis, L lateral heal fluid filled blister, L ischium stage III pressure injury and R medial thigh stage III pressure injury dated 2/26/25 for Resident 3. DSD stated these assessments should have been completed. During an interview on 4/1/25 at 2:13 p.m. with DSD, DSD stated, There are no assessments for resident's [3] wounds for the week of 3/3/25. Wounds should be assessed weekly. During a concurrent interview and record review on 4/1/25 at 2:13 p.m. with DSD, Resident 3's SE, dated 3/12/25 was reviewed. The SE indicated there were no wound measurements for L medial calf, proximal were completed on 3/12/25. DSD stated, There are no wound measurements, and most of the assessment is left blank. This is an incomplete assessment. During an interview on 4/1/25 at 2:13 p.m. with DSD, DSD stated there are no weekly wound assessments completed on 3/12/25 for Resident 3's wounds. During a concurrent interview and record review on 4/1/25 at 2:13 p.m. with DSD, Resident 3's SE, dated 3/18/25 was reviewed. The SE indicated there were no wound measurements for L lateral heel are completed on 3/18/25. DSD stated wound measurements were not completed. During a concurrent interview and record review on 4/1/25 at 2:13 p.m. with DSD, Resident 3's SE, dated 3/18/25 was reviewed. The SE indicated there were no wound assessment for Left Ischium on 3/18/25. DSD stated, This is an incomplete assessment. During a concurrent interview and record review on 4/1/25 at 2:13 p.m. with DSD, Resident 3's SE, dated 3/18/25 was reviewed. The SE indicated there was no wound assessment for Right Medial thigh on 3/18/25. DSD stated, This is not a complete assessment. During an interview on 4/1/25 at 4:09 p.m. with DON, DON stated the expectation of staff is to complete weekly wound assessments for all wounds. During an interview on 4/29/25 at 10:14 a.m. with DON, DON stated previously, all wound treatments and weekly wound assessments were overseen by LVN 1 who is no longer working at [facility]. During an interview on 5/1/25 at 9:48 a.m. with DON, DON stated she oversees LVN 1's wound treatments and she did not review the TAR daily for wound treatment completion. During a review of the facility's policy and procedure (P&P) titled, Wound Care, dated 10/2010, the P&P indicated, Documentation: The following information should be recorded in the resident's medical record: 2. The date and time the wound care was given. 4. The name and title of the individual performing the wound care. 6. all assessment date i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 10. The signature and title of the person recording the data. During a review of the facility's P&P titled, Prevention of Pressure Injuries, dated 4/2020, the P&P indicated, Risk Assessment: 1. Assess the resident on admission (within eight hours) for exiting pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition.