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	06/23/2025

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 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. (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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Wound Care, for one of three sampled residents (Resident 1) when wound care orders were not obtained and care plan interventions were not developed and implemented for Resident 1's right and left heel wounds. These failures resulted in Resident 1 not being provided wound care for nine days and had the potential for worsening of Resident 1's right and left heel wounds.Findings:During a review of Resident 1's Admission/readmission Evaluation/Assessment, (AREA) dated 5/7/25, the AREA indicated, Reason for admission: Skilled needs, wound care, the AREA indicated Resident 1 required assistance with activities of daily living: bathing, dressing, toileting, and bed mobility. The AREA indicated, Resident 1 had a wound to the right heel and a closed blister to the left heel (no measurement or description documented of the wound to the right heel or the blister to the left heel).During a review of Resident 1's Baseline Care Plan (BCP - a foundational document in skilled nursing facilities, the BCP provides initial instructions for providing effective and person-centered care to a newly admitted resident), dated 5/7/25, the BCP indicated under the section titled, Skin Integrity (Prior and Current Concerns), there was no documentation Resident 1 had any current or past skin integrity concerns.During a review of Resident 1's Admissions Minimum Data Set, (MDS - a standardized assessment tool used in healthcare settings to collect comprehensive information about residents) dated 5/12/25, the MDS assessment indicated Resident 1's Brief Interview for Mental Status (BIMS- standardized assessment tool used to evaluate the cognition [mental processes that allow individuals to think, learn, and remember] with scores ranging from 0 - 15 with the higher the score the more intact the resident's cognition is) score was 11 (represents moderately impaired cognition). The MDS assessment indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with rolling left and right (the ability to roll from lying on back to left and right side and return to lying on back on the bed). The MDS assessment indicated Resident 1 had diabetic foot ulcers (an open sore or wound on the foot that occurs in people with diabetes [a diseases that affect how the body uses blood sugar], often due to nerve damage and poor blood circulation).During a review of Resident 1's Skin & Wound Evaluation, (SWE) dated 5/15/25, the SWE indicated Resident 1 had a diabetic wound to the right heel which was present on admission. The SWE indicated the right heel wound measured: area 5.0 centimeter squared (cm 2 - unit of measure), length 3.6 centimeter (cm - unit of measure), and width 1.9 cm.During a review of Resident 1's SWE, dated 5/15/25, the SWE indicated Resident 1 had a diabetic left heel wound that was present on admission. The SWE indicated the left heel wound measured: area 11.5 cm2, length 4.9 cm, and width 3.4 cm.During a review of Resident 1's care plan (is a comprehensive, personalized document that outlines the specific needs of an individual requiring care, detailing the type of support, how it will be provided/interventions, and the goals of the care) initiated 5/8/25, with the focus on Skin: [Resident 1] has diabetic ulcer(s) R (right) heel and is at risk for complications related to decreased mobility, delayed healing. further skin breakdown.infection. There were no interventions added to assist Resident 1's diabetic ulcers in the healing process on 5/8/25. Interventions were not added until 5/28/25 (21 days after Resident 1's wounds were first identified).During a concurrent interview and record review, on 5/28/25 at 4:05 p.m. with Director of Nursing (DON). Resident 1's AREA, dated 5/7/25 was reviewed. DON confirmed Resident 1 had a wound to the right heel and a closed blister to the left heel which were present upon admission with no measurement or description documented. Resident 1's Treatment Administration Record, (TAR) dated May 2025 was reviewed. After reviewing the TAR, DON stated no treatments were performed for Resident 1's right heel or left heel wounds from 5/7/25 to 5/16/25 (9 days). DON reviewed Resident 1's physicians' orders. DON stated the admissions nurse did not obtain treatment orders from the physician to treat the resident right heel and left heel. DON stated no treatments to the right and left heel were documented as being performed from 5/7/25 to 5/16/25 . DON stated, if it [treatment] is not documented it [treatment] is not done. Resident 1's care plans initiated 5/8/25 were reviewed. DON stated no wound care interventions were developed for the wounds to Resident 1's right heel or left heel on the day the care plan was developed. During a concurrent interview and record review, on 6/23/25 at 11:44 a.m. with DON, DON stated a resident's skin should be assessed and wounds should be measured and documented upon admission. DON stated measurements of wounds should be taken when identified to monitor if the wound is worsening. DON stated the resident physician should be notified of the wounds and treatment orders should be obtained and placed in the medical record to be implemented. DON stated a resident with wounds should be placed on the wound

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review, the facility failed to follow their policy and procedures (P&P) titled, Prevention of Pressure Injuries (PI -localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction), Wound Care, and admission Assessment and Follow Up: Role of the Nurse, for one of three sampled residents (Resident 1) when the physician was not notified and treatment orders obtained, a care plan was not developed and implemented, wound measurements were not completed, and an individualized turning/repositioning schedule was not determined, when the resident was admitted with a coccyx (tailbone) PI. These failures resulted in Resident 1 not being provided wound care for nine days and the worsening of Resident 1's pressure injury.Finding:During a review of Resident 1's Admission/readmission Evaluation/Assessment (AREA), (AREA - document used by the facility when a resident is admitted /readmitted to document the assessment including skin assessment) dated 5/7/25 (admission date), the AREA indicated, Reason for admission: Skilled needs, wound care. The AREA indicated Resident 1 was incontinent of bladder and required assistance with activities of daily living (ADLs - refers to basic self-care tasks): bathing, dressing, toileting, and bed mobility. The AREA indicated Resident 1 had a pressure injury to the coccyx (tailbone). There was no documentation measurements or a description of Resident 1's pressure injury to the coccyx. During a review of Resident 1's Braden Scale for Predicting Pressure Ulcer Risk Evaluation, (Braden Scale is risk assessment tool used to predict the likelihood of a resident developing pressure injuries with the scores ranging from 6 - 23, with the lower the score the higher the risk for developing a pressure injury) dated 5/7/25, Resident 1's Braden score was 14 (score of 13-14 indicates a moderate risk for developing a pressure injury).During a review of Resident 1's care plan (comprehensive, personalized document that outlines the specific needs of an individual requiring care, detailing the type of support, how it will be provided/interventions, and the goals of the care) initiated 5/8/25, with the focus on Skin: [Resident 1] is at risk for skin breakdown related to edema (swelling of the body tissue), impaired mobility, pain, Braden Score :14. The care plan interventions included, Assist to turn and reposition as indicated/tolerated. Keep skin clean and dry to the extent possible. The care plan did not include an individualized turning/repositioning schedule. During a review of Resident 1's Minimum Data Set, (MDS - a comprehensive assessment tool to evaluate the functional capabilities and health needs of residents) dated 5/12/25, the MDS indicated, Resident 1's BIMS (Brief Interview for Mental Status- standardized assessment tool used to evaluate the mental processes that allow individuals to think, learn, and remember) score was 11 (score between 8 to 12 indicates moderately impaired cognition). The MDS indicated Resident 1 was dependent (helper does all the effort) for toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement), and required substantial/maximal assistance (helper does more than half the effort) with rolling to the left and to the right (the ability to roll from lying on back to left and right side and return to lying on back on the bed). The MDS indicated Resident 1 had one or more unhealed pressure injuries, one unstageable pressure injury (obscured full - thickness skin and tissue loss. Full - thickness skin and tissue loss in which the extent of tissue damage within the PI cannot be confirmed because it is obscured by slough [yellow or white material consisting of dead cells which attaches to the wound bed] or eschar [dead tissue that forms over healthy skin]. If slough or eschar is removed, a Stage 3 [Full-thickness loss of skin, in which adipose (fat) is visible] or Stage 4 [Full-thickness skin and tissue loss with exposed muscle, tendon (flexible tissue, similar to a rope), ligament [a band of tissue that connects bones, joints or organs], cartilage [a strong, flexible connective tissue that protects joints and bones] or bone are visible in the pressure injury] are revealed) presenting as a deep tissue injury (intact or non-intact skin with localized area of persistent non-blanchable [the skin does not turn white when touched with a finger] deep red, maroon, purple discoloration or epidermal [outer layer of skin] separation revealing a dark wound bed or blood-filled blister [raised skin filled with fluid]) present on admission.During a review of Resident 1's Skin & Wound Evaluation (SWE - document used by the facility to document the resident's skin condition), dated 5/15/25, the SWE indicated Resident 1 had a stage 4 pressure injury present on admission. There was no documentation of the location of the PI. The SWE indicated the wound measured: area 16.8 centimeters squared (cm2 - unit of measurement), length 8.2 centimeters (cm - unit of measurement), and width 5.2 cm. No depth of the wound was documented. During a review of Resident 1's SWE, dated 5/21/25, the SWE indicated Resident 1 had a stage 4 pressure injury to the coccyx, present on admission. The SWE indicated

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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. Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment for one of three sampled residents (Resident 2) when:1. A low air loss mattress (a specialized medical mattress designed to prevent and treat pressure injuries [PI - localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction] by providing a combination of air circulation and pressure redistribution) was improperly installed. This failure resulted in Resident 2 hitting his head.2. The wheelchair was not maintained and could not be properly cleaned and sanitized. This failure had the potential for Resident 2 to be exposed the infection and bacteria.Findings:1. During a review of Resident 2's Minimum Data Set, (MDS - a comprehensive assessment tool to evaluate the functional capabilities and health needs of residents) dated 5/18/25, the MDS indicated, Resident 2's BIMS (Brief Interview for Mental Status - standardized assessment tool used to evaluate the mental processes that allow individuals to think, learn and remember) score was 12 (a score of 8 to 12 indicates moderately impaired cognition).During a concurrent observation and interview, on 5/28/25 at 1:46 p.m. with Resident 2 in Resident 2's room, Resident 2 stated his low air loss mattress was installed wrong and the machine has hit him in the head a few times. The machine (the air hose connectors) was observed at the head of the bed on the floor. Resident 2 stated he has been here for two weeks and the bed has been like this. Resident 2 stated he made a certified nursing assistant (CNA) aware and the CNA said he would change it but the CNA never changed the set up of the low air loss mattress.During a concurrent observation and interview, on 5/28/25 at 2:20.p.m. with Maintenance Director (MD), in Resident 2's room. MD stated he does assist in installing the low air loss mattresses when a nurse asks. MD stated he helps strap the mattress to the bed frame and plugs it in. MD confirmed Resident 2's low air loss mattress and the air hose connectors were located at the head of the bed and resting on the floor. During an interview on 5/28/25 at 3:54 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated low air loss mattress' air hose connectors should be placed at the foot of the bed. During a review of the facility provide manual titled, A10, Low Air-Loss Mattress Replacement System With Alternating Pressure, undated, the manual indicated, Installation 1. Place the mattress directly on the bed frame, with the air hose connectors positioned at the footboard. 2. Hang the pump onto the bed board (footboard side) .2. During a concurrent observation and interview, on 5/28/25 at 1:46 p.m. with Resident 2 in Resident 2's room, Resident 2 stated the facility provide him with his current wheelchair. Resident 2 stated he received the wheelchair with cracks and a right arm rest peeling. Resident 2 stated he put the hot pink duct tape on the left arm rest. During a concurrent observation and interview, on 5/28/25 at 2:20.p.m. with MD, in Resident 2's room, MD confirmed Resident 2's wheelchair right arm rest was cracked and peeling and the left arm rest had hot pink duct tape on more than half of the arm rest. DM stated he could not say if Resident 2's wheelchair arm rest could be sanitized. During an interview on 5/28/25 at 3:54 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated residents with cracked or peeling arm rest on wheelchairs, should have the arm rest replaced. LVN 1 stated cracked and peeling arm rest could not be sanitized.During a review of the facility policy and procedure (P&P) titled, Infection Prevention and Control Program, revised October 2018, the P&P indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 11. Prevention of Infection . (8) following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC).