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	07/11/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (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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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&P) on Urinary Catheter (a tube placed in the body to drain and collect urine from the bladder) Care for two of five sampled residents (Resident 1 and Resident 2) when:1. The facility did not monitor placement of urinary catheter for Resident 1.2. The facility did not document urine output according to the plan of care for Resident 2.These failures had the potential for Resident 1 and Resident 2 developing UTI (Urinary Tract Infection - bladder infection).Findings:1. During a review of Resident 1's admission Record (AR), dated 7/10/25, the AR indicated, Resident 1 is a [AGE] year-old male with a diagnosis of OBSTRUCTIVE AND REFLUX UROPATHY (blockage of flow of urine from the kidneys to the bladder and backward flow of urine from the bladder into the ureters and potentially back to the kidneys).During a review of Resident 1's Order Summary Report (OSR), dated 7/10/25, the OSR indicated, Suprapubic catheter:_16_F [French (refers to the size of the urinary catheter)]/ [per] 10cc [unit of measurement in cubic centimeter] for: obstructive uropathy [a condition where urine flow is blocked, causing it to back up and potentially damage the kidneys]. Change PRN [as needed] for accidental removal or blockage every shift. Order Date. 01/10/2025. During a review of Resident 1's SBAR (Situation, Background, Assessment, Recommendation), dated 6/25/25, the SBAR indicated, Resident [1] told nurse its [sic] burning when he urinates, nurse noticed residents [sic] catheter bag and tubing is empty, and urine and blood are coming from residents [sic] penis and catheter site. to send resident to ER [Emergency Room] for suprapubic catheter complications.During a concurrent interview and record review on 7/10/25 at 12:47 p.m. with Minimum Data Set Coordinator (MDSC), Resident 1's Care Plan (CP), dated 1/19/25 was reviewed, the CP indicated, [Resident 1] has a suprapubic catheter and is at risk for complications with urinary system. Change PRN for accidental removal or blockage. Goal. [Resident 1] will be/(or) remain free from (suprapubic) catheter-related trauma. Interventions. Check [Resident 1's] tubing [urinary catheter] for kinks [bend or twist] (#[number] TIMES) each shift. Monitor and document intake and output as per facility policy. MDSC stated, I don't see that it's [checking the tubing for kinks and urine output] being monitored. During a concurrent interview and record review on 7/10/25 at 12:47 p.m. with MDSC, Resident 1's Task: Bladder Continence (TBC), dated 6/11/25-7/10/25 was reviewed. The TBC indicated there was no documentation of urine output on 6/11/25-6/22/25. The TBC, dated 6/14/25 indicated, HIS [Resident 1] CATHETER CLOGGED AND HE USED THE RESTROOM TO URINATE. The TBC dated 6/15/25 indicated, catheter has been blocked, and he uses the restroom. MDSC stated there was no documentation of interventions to address when Resident 1's suprapubic catheter was clogged or blocked. MDSC stated when it was first noted there was no urine output, the licensed nurse and the physician should have been notified.During an interview on 7/31/25 at 3:33 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated she did not document Resident 1's suprapubic catheter was clogged on 6/25/25. CNA 2 stated if it (clogged suprapubic catheter) was not documented, it did not happen. 2. During a review of Resident 2's AR, dated 7/10/25, the AR indicated, Resident 2 is an [AGE] year-old male with a diagnosis of INFECTION AND INFLAMMATORY (body's natural response to injury or infection) REACTION DUE TO INDWELLING URETHRAL CATHETER (tube inserted through the urethra into the bladder to drain urine).During a review of Resident 2's OSR, dated 4/22/25, the OSR indicated, Foley Catheter (tube inserted into the bladder through the urethra to drain urine): 18F/10cc for: obstructive uropathy. Change PRN for accidental removal or blockage.During a review of Resident 2's SBAR, dated 6/4/25, the SBAR indicated, The patient [Resident 2] complained about pressure at the lower abdominal area and blood in urine. The UA [Urinalysis (lab test that examines the urine)] with C&S [Culture and Sensitivity (identifies the germs causing the infection) results was notified to MD [Medical Doctor] and the new order received. Omnicef [antibiotic medicine that fight bacterial infections].During a review Resident 2's Nurse's Note (NN), dated 6/21/25, the NN indicated, pt [patient/Resident 1] was c/o [complained of] severe pain r/t [related to] foley catheter and unable to have [urine] output. Pt stated his bladder feels full but unable to urinate. pain and bleeding in penile [relating to or affecting the penis] area. MD made aware and gave order to send out to ER for further eval [evaluation].During a review of Resident 2's hospital's History and Physical (H&P), dated 6/21/25, the H&P indicated, The patient's [Resident 1] daughter reports that the patient was complaining of nausea [feeling of sickness in the stomach that may come with an urge to vomit], decreased appetite, and suprapubic discomfort for a few days. They noticed the decreased urine output today. The patient had significant

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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 ensure:A Certified Nursing Assistant (CNA) 2 was wearing proper personal protective equipment (PPE) when entering one of nine sampled residents' (Resident 6) room on contact precautions (to use PPE before entering residents' room with residents known or suspected to be infected with germs that can be spread by direct contact). This failure had the potential to result in spread of infection to other residents, staff, and visitors.2. A Licensed Vocational Nurse (LVN) performed hand hygiene after removing used gloves during a suprapubic catheter (a tube that drains urine from the bladder through a small opening in the lower abdomen) care for one of five sampled residents (Resident 3). This failure had the potential to result in Resident 3 developing urinary tract infection (bladder infection). Findings:1. During a review of Resident 6's admission Record (AR), dated 7/10/25, the AR indicated, Diagnosis. EXTENDED SPECTRUM BETA LACTAMASE (ESBL) RESISTANCE [bacteria that is resistant to common antibiotics (medication that treats bacterial infection].During a review of Resident 6's Order Summary Report (OSR), dated 7/10/25, the OSR indicated, Contact Isolation due to VRE [Vancomycin-Resistant Enterococci-bacteria that is resistant to the antibiotic Vancomycin] and ESBL in urine. During a concurrent observation and interview on 7/10/25 at 3:38 p.m. with Certified Nursing Assistant (CNA) 2 in Hallway 1. Resident 6's room had a Contact Precautions sign on her door. The Contact Precautions sign indicated staff should wear gown and gloves when entering resident's room. CNA 2 was not wearing a gown while transferring Resident 6 from the bed to the wheelchair. CNA 2 stated she did not know Resident 6 was on contact precautions. CNA 2 stated she was supposed to wear gown and gloves in Resident 6's room to protect herself, and to not spread microorganisms to other residents.During a concurrent observation and interview on 7/10/25 at 3:40 p.m. with Infection Control Preventionist (ICP) in Hallway 1. Housekeeping (HSK) was not wearing a gown while cleaning the bed in Resident 6's room. ICP stated HSK was supposed to wear gown in Resident 6's room because Resident 6 was on contact precautions. During a concurrent interview and record review on 7/10/25 at 3:56 p.m. with ICP, the facility's policy and procedure (P&P) titled, Isolation - Categories of Transmission-Based Precautions, dated September 2022 was reviewed. The P&P indicated, Contact Precautions. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. ICP stated the P&P was not followed.2. During a review of Resident 3's Order Summary (OS), dated 12/20/23, the OS indicated, Suprapubic Foley catheter care q [every] shift.During a concurrent observation and interview on 7/11/25 at 10:57 a.m. with LVN 2 in Resident 3's room, LVN 2 performed suprapubic catheter care for Resident 3. LVN 2 cleaned Resident 3's suprapubic catheter insertion site then LVN 2 removed her gloves and wore new gloves without performing hand hygiene in between glove changes. LVN 2 stated she should have washed her hands after cleaning the insertion site and after removing her used gloves.During a concurrent interview and record review on 7/11/25 at 11:42 a.m. with ICP, the facility's P&P on Suprapubic Catheter Care, dated October 2010 was reviewed. The P&P indicated, The purpose of this procedure is to prevent skin irritation around the stoma site and to prevent infection of the resident's urinary tract. Wash around the catheter site with soap and water. Wash the outer part of the catheter tube with soap and water. Remove gloves and discard in designated container. Wash and dry your hands thoroughly. ICP stated the P&P was not followed.