

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: 056294	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER San Joaquin Nursing Center and Rehabilitation Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 store, prepare, and distribute food in a sanitary manner when: 1. Sheet pans and dry storage bins were stored upside down while wet, with food debris and sticky residue adhered to their surfaces. 2. A dirty dining cart was stored in the walk-in refrigerator, not cleaned and disinfected. 3. Label on a container used to store garlic bread in the walk-in refrigerator had the wrong use-by date. 4. A (Brand) floor mixer had black residue buildup underneath the splash guard and splashes of light brown residue in mixing bowl. 5. A commercial can opener had black residue buildup on the cutting blade. 6. A meal slip (paper ticket that goes onto residents' food tray to ensure the correct food is served based on their needs and preferences) fell and the corner of the slip touched the edge of the gravy pan. 7. Fruit salad was left at room temperature for 37 minutes, then returned to its original container and refrigerated. The temperature of the fruit salad was 43 degrees Fahrenheit (43 F). These failures posed the risk of foodborne illness in a medically fragile resident population of 88 facility residents who received food prepared in the kitchen. Findings: 1. During a concurrent observation and interview on 3/9/2026 at 2 p.m. with the Dietary Director (DD), in the kitchen, 14 sheet pans of various sizes were stacked and stored upside down. The pans had large water stains and were stored wet. Food debris and/or sticky residue were observed on five of the 14 sheet pans that were stored for use. The DD confirmed the pans were wet and unclean. The DD stated the pans needed to be rewashed due to the risk for bacteria [germs] growth. During a concurrent observation and interview on 3/9/2026 at 2:45 p.m. with the DD, in the kitchen, plastic storage bins were stacked and stored upside down. Nine bins had residual moisture inside the bins, two bins had black speckles and sticky residue adhered to their surfaces. The DD stated the bins needed to be rewashed and fully air dried before storage. The DD stated the moisture could foster bacterial growth and residents can get sick. During a review of the P&P titled Sanitization dated 11/2022, the P&P indicated, . All utensils, counters, shelves and equipment are kept clean .All equipment, food contact surfaces and utensils are cleaned and sanitized . food preparation equipment and utensils that are manually washed are allowed to air dry . 2. During a concurrent observation and interview on 3/9/2026 at 2:15 p.m. with the DD and Certified Dietary Manager (CDM), in the walk-in refrigerator, a food cart was sticky and had dust and food particles on its surface. The DD confirmed the cart was not clean and stated staff should have wiped down the cart before storing it in the walk-in refrigerator. The DD stated it was not sanitary to store dirty food carts in the walk-in refrigerator next to food items. During a review of the P&P titled Food Receiving and Storage dated 11/2022, the P&P indicated, . Foods shall be received and stored in a manner that complies with safe food handling practices . During a review of the P&P titled Sanitization dated 11/2022, the P&P indicated, . All utensils, counters, shelves and equipment are kept clean . 3. During a concurrent observation and interview on 3/9/2026 at 2:15 p.m. with the DD and CDM, in the walk-in refrigerator, one plastic bin containing slices of bread was labeled Garlic Bread .Prepared date 2/26/2026 .Use by 6/26/2026. The CDM pulled the bread off the shelf and stated bread was stored in the walk-in refrigerator for up to three months. The CDM stated the incorrect use-by date could result in the bread being used past expiration. During a review of the P&P titled Food Receiving and Storage (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dated 11/2022, the P&P indicated, . Foods shall be received and stored in a manner that complies with safe food handling practices . refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded . During review of a facility document titled Dry Food Storage Guidelines undated, the document indicated, .Bread .Unopened on Shelf .5-7 days .Opened on Shelf .5-7 days .Opened Refrigerated .3 months, frozen . 4. During a concurrent observation and interview on 3/9/2026 at 2:18 p.m. with the DD and CDM, in the kitchen, one large food mixer the CDM referred to as [Brand] floor mixer had thick black residue at the attachment hub where the splash guard set. The mixing bowl had light brown food residue adhered to the inside of metal bowl. The DD confirmed the mixer was not thoroughly cleaned and stated staff did not remove the splash guard as part of staff's daily routine cleaning. During a review of the P&P titled Sanitization dated 11/2022, the P&P indicated, .When cleaning fixed equipment (e.g., mixers .the removable parts are . Washed and sanitized and non-removable parts cleaned with detergent and hot water, rinsed, air dried and sprayed with a sanitizing solution (at the effective concentration) . 5. During a concurrent observation and interview on 3/9/2026 at 2:35 p.m. with the DD, in the kitchen, the commercial can opener's cutting blade had thick black buildup adhered to it. The DD stated the condition of the can opener was unclean and had the potential to contaminate food items opened by the can opener. During a review of the P&P titled Sanitization dated 11/2022, the P&P indicated, . All equipment, food contact surfaces and utensils are cleaned and sanitized . 6. During an observation on 3/10/2026 at 11:55 a.m. in the kitchen, the DC plated hot foods held on the steam table during tray line (a fast-paced assembly line used to prepare resident food). The DC dropped a meal slip, and the corner of the slip contacted the edge of the gravy pan. The DC immediately removed the meal slip from the side of the gravy pan, then continued to plate the gravy. During an interview on 3/10/2026 at 12:45 p.m. with the DD, the DD stated the DC should have discarded the gravy after the meal slip fell near the gravy pan. The DD stated it was unsanitary and potentially posed a risk to the residents. During a review of the P&P titled Food Preparation and Service dated 11/2022, the P&P indicated, . Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices . appropriate measures are used to prevent cross contamination [transfer of germs from on surface, food, or person to another] . 7. During an observation on 3/10/2026 at 12:03 p.m. in the kitchen, Dietary Aid (DA) 1, removed fruit salad from the refrigerator. During a concurrent observation and interview on 3/10/2026 at 12:29 p.m. with DA 1, in the kitchen, DA 1 used a 1/3 cup scoop to plate the fruit salad into small bowls in preparation for dinner service. DA 1 plated eight bowls then rechecked the menu. DA 1 stopped plating the fruit salad and stated he used the incorrect scoop size. Eight bowls of fruit salad and original container were left on the preparation table. During an observation on 3/10/2026 at 12:40 p.m. in the kitchen, with the DD, DA 1 returned the fruit salad plated earlier to the original container. DA 1 took the fruit salad's temperature which registered at 43 F. DA 1 covered the container with foil and placed it back into the refrigerator. During an interview on 3/10/2026 at 12:45 p.m. with the DD, the DD stated the fruit salad sat out for too long and came up to temperature, therefore should not be refrigerated again. The DD stated there was a risk for bacteria to grow and the fruit salad was discarded for resident safety. During a review of the P&P titled Food Preparation and Service dated 11/2022, the P&P indicated, . Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices . the danger zone for food temperature is above 41 Fahrenheit and below 135 F. This temperature range promotes the rapid growth of pathogenic microorganisms [germs] that cause foodborne illness . the longer foods remain in the danger zone the greater the risk for growth of harmful pathogens [germs]. Therefore, PHF [potentially hazardous foods] must be maintained at or below 41 F or at above 135 degrees Fahrenheit . During a review of the P&P titled Food receiving and Storage dated 11/2022, the P&P indicated, . Foods shall be received and stored in a manner that complies with safe food handling practices . PHF/TCS [temperature control for safety- must be kept out of the 41 F to 135 F danger zone] foods are stored at or below 41 F, unless otherwise specified by law .		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain professional standards for three of 18 sampled residents (Resident 1, 106 and 121) and two unsampled residents (Resident 70 and 118) when: 1.Registered Nurse (RN) 1 did not verify identity before giving intravenous medication (IV, medication administered directly into the vein), did not label IV medication and tubing to Resident 121. This failure had the potential to cause harm to the resident.2.Peripherally inserted central catheter (PICC line, a long, thin flexible tube inserted into upper arm's vein and guided into a large vein above the heart, to administer medication) dressing was not changed for Resident 121. This failure had the potential to cause harm to the residents. 3.Resident 70's Medication Administration Record (MAR) was signed by LVN 5 without the medication being given. This failure placed Resident 70 at risk for seizures. 4. Resident 106 received the necessary respiratory (the process of breathing) care (respiratory treatment/ therapy, oxygen therapy) and services with a current physician's order. This placed Resident 106 at risk for being given too low or too high oxygen which could lead to respiratory failure. 5. Oxygen tubing was not labeled for Resident 118. This failure had the potential to result in the use of outdated or contaminated tubing, and negative health outcomes for Resident 118.6. Measurements for the peripherally inserted catheter (PICC line- a flexible tube inserted into a large vein near the heart) were not done for Resident 121. This failure had the potential to result in the inability to properly monitor PICC line placement and compromised the safe administration of intravenous (IV- in a vein) therapy. 7. A Registered Nurse (RN) did not assess Resident 1 during Resident 1's stay at the facility from 1/21/2026 through 3/10/2026. This failure had the potential to result in inaccurate or incomplete assessments of Resident 1's condition and lead to inappropriate care planning services and treatments. Findings: 1.During a review of Resident 121's admission Record (AR), dated 3/12/2026, the AR indicated, Resident 121 was admitted to the facility on [DATE] with diagnoses which included polyneuropathy (a condition where many nerves outside the brain and spinal cord are damaged), local infection of the skin and acute osteomyelitis (bone infection). During an observation on 3/10/2026 at 7:55 a.m. in Resident 121's room, RN 1 was observed walking into Resident 121's room, cleaning Resident 121's PICC line, connecting the IV tubing to the PICC line, and hanging IV medication. The IV medication and the IV tubing did not have any label. During an interview on 3/10/2026 at 8:07 a.m. outside Resident 121's room, RN 1 stated she did not identify the right patient and the right medication. RN 1 further stated she administered the IV medication without the resident's label (pharmacy label) and she did not label the IV tubing. RN 1 stated it was wrong practice because labeling and checking the identifier was expected to ensure medication was administered to the right patient at the right time and to communicate with other staff when IV tubing needed to be changed. During an interview on 3/12/2026 at 2:30 p.m. with the Director of Nursing (DON), DON stated the expectation was for all IV medications to be verified prior to administration by checking residents' pictures that were attached to their electronic medical records. DON further stated all IV medications and tubings were expected to be labeled. DON stated these practices were expected as a professional standard of practice to ensure six medication rights and prevent medication errors. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated, . The individual administering medications verifies the resident's (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	identity before giving the resident his/her medications. Methods of identifying the resident include: . checking photograph attached to medical record . During a review of the facility's P&P titled, Intravenous Therapy, [undated], the P&P indicated, . All IV tubing is to be labeled with date, time and initials. 2.During a review of Resident 121's admission Record (AR), dated 3/12/2026, the AR indicated, Resident 121 was admitted to the facility on [DATE] with diagnoses which included polyneuropathy (a condition where many nerves outside the brain and spinal cord are damaged), local infection of the skin and acute osteomyelitis (bone infection). During a concurrent observation and interview on 3/10/2026 at 9:20 a.m. with RN 1 in Resident 121's room, Resident 121's PICC line dressing was dated 2/23/26. Changed 3/1/26. The PICC line dressing was not changed in nine days. RN 1 stated it must had been overlooked and it was important to change the dressing every 7 days and as needed because it followed MD order and facility's policy and procedure (P&P) to prevent infection. During an interview on 3/12/2026 at 2:30 p.m. with the Director of Nursing (DON), DON stated the expectation was for all PICC line dressing to be changed every 7 days or as needed to prevent infection. During a review of the facility's P&P titled, Central Venous Catheter Dressing Change, [undated], the P&P indicated, . Change transparent semi-permeable membrane (TSM) dressing at least every 5-7 days and PRN (when wet, soiled, or not intact) . 3. During a concurrent observation, interview and record review on 3/11/2026 at 2:42 p.m. with Licensed Vocational Nurse (LVN) 4 in the B-Wing Hallway, there was a medication cart with a locked drawer and on top of it was a Controlled Drug Record binder. Scheduled medications (medications with high potential for abuse and/or addiction) and antibiotics bubble packs (a form of tamper -evident packaging where an individual pushes individual sealed tablets though the foil to take the medication) were inside. There was a bubble pack for Lacosamide with 9 tablets taken. The pharmacy label indicated one tablet to be taken twice a day (9am and 9pm). The record for Lacosamide was reviewed. The record indicated nine signatures for March 6th at 2100 (9pm, 2nd dose for the day) to March 11th at 2100. Only one dose was given on 3/8/2026 at 2100. LVN 4 stated the 9am dose for Lacosamide for Resident 70 was not given. Resident 70's MAR was reviewed. The MAR indicated on 3/8/2026, the Lacosamide was given to Resident 70 at 0900 (9am) and 2100. The 9am schedule was signed by LVN 5 but the medication was not given. During a concurrent interview and record review on 3/12/2026 at 9:05 a.m. with LVN 5, Resident 70's MAR was reviewed. The MAR indicated the 9am and 9pm doses on 3/8/2026 were given. LVN 5 stated the 9am dose of the Lacosamide was not given to Resident 70. LVN 5 stated, Only 1 was given. I do not remember why I did not get to give the medication and I signed it. LVN 5 stated the medication (Lacosamide) should have been given then the MAR signed. LVN 5 stated the MAR should reflect what was actually given to the resident to be able to monitor the effect of the medication and patient's safety. During an interview on 3/12/2026 at 2:29 p.m. with the Director of Nursing (DON), the DON stated the LVN should not have signed the MAR if the medication was not given to Resident 70. The DON stated the MAR should accurately reflect if the Resident 70 received or refused his medication for resident (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	safety. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated, . Medications are administered in a safe and timely manner, and as prescribed . 22. The individual administering the medication initials the resident's MAR on the appropriate line after giving the medication . 4. During a concurrent observation and interview on 3/9/2026 at 2:10 pm. with Resident 106 in her room, Resident 106 was lying in bed with head elevated. Resident 106 had a nasal cannula (NC) connected to an oxygen concentrator (a medical device that pulls ambient air and delivers pure oxygen) @ 4L/min (Liters per minute &ndash; unit of measure). Resident 106 stated she had been on oxygen therapy due to shortness of breath. During a concurrent observation and interview on 3/9/2026 at 3:45 pm. with Restorative Nursing Assistant (RNA) in Resident 106's room, RNA checked Resident 106's oxygen concentrator. RNA stated, It's [oxygen flow rate] at 4L/min. RNA stated Resident 106 had been on oxygen for some time. During a concurrent observation, interview and record review on 3/11/2026 at 2:57 p.m. with Licensed Vocational Nurse (LVN) 2, in Resident 106's room. Resident 106 had oxygen via nasal cannula. LVN 2 stated, It's at 3L/min. Resident 106's Physician's Orders was reviewed. LVN 2 stated there was no order for oxygen therapy. LVN 2 stated there should have been an order since Resident 106 had been on oxygen for a long time. LVN 2 stated, Without any orders we should not be giving anything [medication/treatment]. LVN 2 stated the physician order was needed to let staff know how much oxygen was safe to give to the resident. During an interview on 3/12/2026 at 2:35 p.m. with the Director on Nursing (DON), the DON stated there should have been an order for oxygen therapy for Resident 106. DON stated, So that we give the O2 [oxygen] rate as prescribed by the doctor, provide the proper care. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 10/2010, the P&P indicated, Verify that there is a physician's order . 5. During an observation on 3/9/2026 at 3:15 p.m. in Resident 118's room, Resident 118 was connected to an oxygen concentrator (a medical device that supplies oxygen). The tubing and humidifier (medical device to add moisture) used for the supplemental oxygen were not labeled with the date and time. During a concurrent observation and interview on 3/9/2026 at 3:19 p.m. with MDS Coordinator (MDSC), in Resident 118's room, the MDSC inspected the humidifier device and oxygen tubing and confirmed the tubing and humidifier were not labeled. The MDSC stated Resident 118 was admitted to the facility yesterday and a label should have been affixed to the tubing upon admission. The MDSC stated facility process was to change oxygen tubing and humidifier weekly and as needed. During an interview on 3/12/2026 at 12:31 p.m. with the Director of Nursing (DON), the DON stated oxygen tubing and humidifier should be labeled with the date and time to ensure the tubing and humidifier were changed every seven days. The DON stated that weekly changes were necessary to prevent respiratory complications. The DON confirmed the facility's policy and procedure (P&P) titled Oxygen Administration did not address the labeling of tubing; however facility practice was to label (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tubing with date and time and Resident 118's tubing should have been labeled. 6. During a concurrent observation and interview on 3/9/2026 at 3:32 p.m. in Resident 121's room, Resident 121 stated he was recently admitted to the facility for wounds and pointed to a vascular access device (tube inserted in a vein) inserted into his right upper arm. During review of Resident 121's admission Record (AR- a document that contains essential information about a resident), undated, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of infection following a procedure. During review of Resident 121's Admission/ readmission Evaluation/Assessment (AA) dated 3/1/2026, the AA indicated Resident 121's vascular access device was a PICC line to the right upper arm that was free of redness or drainage (fluid oozing). The AA did not indicate PICC line measurements or when the transparent dressing was last changed. During review of Resident 121's IV Administration Record (IVR) dated 3/1/2026 through 3/31/2026, the IVR indicated Resident 121's PICC line dressing was changed and catheter length measured on 3/3/2026 and 3/10/2026. During a concurrent interview and record review on 3/12/2026 at 12:03 p.m. with the DON, the DON reviewed Resident 121's medical record for the PICC line measurements. The DON stated that the record indicated Resident 121's PICC line dressing was changed on 3/3/2026 and 3/10/2026. The DON stated the record did not indicate the catheter's length was measured on 3/10/2026. During an interview on 3/12/2026 at 12:20 p.m. with Registered Nurse (RN) 1, RN 1 stated she changed Resident 121's PICC line dressing on 3/10/2026 but forgot to document the catheter's measurements. RN 1 validated it was important to document PICC line measurements to ensure the PICC line was working properly and Resident 121 was tolerating IV medications. During a review of Resident 121's Order Summary Report (OSR) dated 3/2/2026, the OSR indicated, PICC (all types) Measure catheter length with each dressing change. 7. During review of Resident 1's admission Record (AR- a document that contains essential information about a resident), undated, the AR indicated Resident 1 was admitted to the facility on [DATE]. During review of Resident 1's History and Physical (HP- a comprehensive document that records medical history and detailed physical examination) dated 1/22/2026, the HP indicated, .medical history significant for hypertension [high blood pressure], aortic stenosis [stiff heart valve-right] .heart failure [weak heart] .peripheral arterial disease [stiff or blocked veins and arteries], diabetes [high sugar in blood] .COPD [Chronic Obstructive Pulmonary Disease, lung disease] .septic shock [life threatening infection in body] secondary to UTI [urine infection] .admitted to the [facility] for strengthening and endurance training .as well as management of underlying comorbidities . During review of Resident 1's Admission/ readmission Evaluation/Assessment (AA) dated 1/21/2026, the AA indicated the assessment was completed by Licensed Vocational Nurse (LVN) 3. During a concurrent interview and record review on 3/12/2026 at 9:08 a.m. with the MDS Coordinator (MDSC- a licensed nurse who manages the minimum data set [MDS]- a clinical assessment tool used (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to evaluate the health, functional status, and care needs of residents), the MDSC reviewed Resident 1's medical record. The MDSC stated she completed Resident 1's MDS assessment on 2/3/2026. The MDSC stated no RN reviewed the MDS upon its completion. The MDSC stated Resident 1's record did not indicate a RN assessed and coordinated care for Resident 1 when admitted . The MDSC stated she was an LVN. During a concurrent interview and record review on 3/12/2026 at 12:03 p.m. with the Director of Nursing (DON), the DON reviewed Resident 1's assessment, including admission and discharge assessments, and care plan. The DON stated there was no indication a RN evaluated the care provided to Resident 1. The DON stated Resident 1 should have been assessed by an RN due to the complexity of Resident 1's condition. The DON acknowledged the importance of RN oversight for accurate and safe provision of care to the residents. During a review of the facility's document titled Job Description: Registered Nurse (RN) undated, the job description indicated, . Admit, transfer, and discharge residents as required .Ensure that direct nursing care be provided by a licensed nurse, a certified nursing assistant, and or a nurse aid trainee qualified to perform the procedure . review nurses notes to ensure that they are informative and descriptive of the nursing care being provided, that they reflect the residents response to the care, and that such care is provided in accordance with the residents wishes .Review medication cards for completeness of information, accuracy in the transcription of physician orders, and adherence to stop order policies . Participate in the development of written preliminary and comprehensive assessments of the nursing needs of each resident as necessary . Ensure that all personnel involved in providing care to the resident are aware of the residents care plan. Ensure that nursing personnel refer to the residents care plan prior to administering daily care to the resident .		

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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 follow infection control practices for two unsampled residents (Residents 22 and 128) when: 1.CNA (Certified Nursing Assistant) 1 did not perform hand hygiene and wore a gown while providing care to Resident 22 who was on Enhanced Barrier Precautions (EBP, infection control intervention designed to reduce the spread of multidrug-resistant organism, MDROs - a germ that is resistant to many antibiotics). 2.CNA 1 did not perform hand hygiene before and after repositioning Resident 128. 3. Licensed Vocational Nurse (LVN) 1 did not perform hand hygiene in accordance with facility policy and procedure and infection prevention and control guidelines for Clostridioides Difficile (C. difficile- contagious bacteria that causes diarrhea and inflammation of the colon). 4. LVN 1 used a medication tray in Resident 66's room who was on transmission-based precautions (a measure used to prevent the spread of a suspected or known infection) for C. difficile, then reused the tray without disinfecting it in Resident 121's room who was on enhanced barrier precautions (EBP- an infection control intervention to reduce the spread of germs). These failures placed residents at risk for cross contamination and infection and could result in health-related disease. Findings:Findings: 1.During a review of Resident 22's admission Record (AR), dated 3/12/2026, the AR indicated Resident 22 was admitted to the facility on [DATE] with a diagnosis of metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood). During an observation on 3/11/2026 at 2:59 p.m., outside of Resident 22's room, an EBP sign was posted next to Resident 22's name. The EBP sign indicated, EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities . Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting . Further observation indicated CNA 1 went inside Resident 22's room without performing hand hygiene, grabbed and wore new pair of gloves, and proceeded with changing Resident 22's brief and bed sheets. CNA 1's clothes touched Resident 22's bed sheets. CNA 1 placed the dirty bed sheets into a dirty linen containers outside Resident 22's room. CNA 1 removed her and did not perform hand hygiene. During an interview on 3/11/2026 at 3:13 p.m. with CNA 1, outside the Resident 22's room, CNA 1 stated she did not wear any gown and wearing gloves was enough. CNA 1 stated she should had worn gloves and gowns when changing linen and providing hygiene to EBP residents to protect residents from infection. During interviews on 3/11/2026 at 4:20 p.m. and on 3/12/2026 at 2 p.m. with the Infection Preventionist (IP), the IP stated, Gown and gloves had to be worn during changing adult brief and bed sheets in EBP residents to prevent the spread of MDRO . It was imperative to practice hand hygiene before, after and in between caring ofr any resident. It is the most important thing to prevent transmittal of disease. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated February 2025, the P&P indicated, . Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the trasmission of multi-drug resistant organisms (MDROs) to residents . Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing . d. providing hygiene; e. changing linens; f. changing briefs . (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's P&P titled, Handwashing/Hand Hygiene, dated October 2023, the P&P indicated, . Hand hygiene is indicated: a. immediately before touching a resident . d. after touching a resident . 2. During an observation on 3/11/2026 at 3:14 p.m. inside of Resident 128's room, CNA 1 observed not performing any hand hygiene before and after repositioning Resident 128's legs. During an interview on 3/11/2026 at 3:16 p.m. with CNA 1, outside Resident 128's room, CNA 1 stated she was not doing hand hygiene before and after Resident 128's care. During a review of Resident 128's admission Record (AR), dated 3/12/2026, the AR indicated Resident 128 was admitted to the facility on [DATE] with a diagnosis of muscle wasting (the loss of muscle tissue, causing muscles to shrink and weaken). During an interview on 3/12/2026 at 2 PM with the IP, the IP stated, It is imperative to practice hand hygiene before, after and in between caring for any resident. It is the most important thing to prevent transmittal of disease. During a review of facility's P&P titled, Handwashing/Hand Hygiene, dated October 2023, the P&P indicated, . Hand hygiene is indicated: a. immediately before touching a resident . d. after touching a resident . 3. During an interview on 3/9/2026 at 4:25 p.m. with LVN 1, LVN 1 stated Resident 66 was on transmission-based precautions for C. difficile. During an observation on 3/9/2026 at 4:33 p.m. LVN 1 donned (put on) PPE and entered Resident 66's room to check his blood sugar. LVN 1 completed her task and removed her PPE. LVN 1 performed hand hygiene using alcohol- based hand rub (ABHR) placed outside Resident 66's room. During an interview on 3/9/2026 at 4:40 p.m. with LVN 1, LVN 1 acknowledged she did not wash her hands after care to Resident 66 was provided. LVN 1 stated facility policy required staff to wash hands with soap and water after staff cared for residents infected with C. difficile to prevent C. difficile from spreading. LVN 1 stated she should have washed her hands with soap and water immediately after she exited Resident 66's room. During an interview on 3/12/2026 at 3:15 p.m. with the Infection Preventionist (IP), the IP stated LVN 1 did not perform proper hand hygiene during the provision of care to Resident 66. The IP stated C. difficile was a contagious infection and washing hands with soap and water was the most effective way to prevent the transmission (spread) of C. difficile. The IP stated LVN 1 did not follow policy and procedure for proper hand hygiene and C. difficile. During a review of the facility policy and procedure (P&P) titled Handwashing/ Hand Hygiene dated 10/2023, the P&P indicated, .The facility considers Hand hygiene the primary means to prevent the spread of healthcare associated infections .all personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors .hand hygiene is indicated .immediately after glove removal .Wash hands with soap and water .after contact with the resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and C. difficile . (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Clostridioides (Clostridium) Difficile dated 12/2024, the P&P indicated, .The primary reservoirs for C. difficile are infected people and surfaces .when caring for residents with CDI [C. difficile infection], staff is to maintain vigilant hand hygiene. Hand washing with soap and water is superior to ABHR for the mechanical removal of C. difficile spores [bacteria cell with hard wall that can reproduce under harsh conditions] from hands . 4. During an interview on 3/9/2026 at 4:25 p.m. with LVN 1, LVN 1 stated Resident 66 was on transmission-based precautions for C. difficile. During an observation on 3/9/2026 at 4:36 p.m. outside Resident 66's room, LVN 1 exited the room holding a blue medication tray and placed the tray on a personal protective equipment (PPE) cart. LVN 1 did not disinfect the tray. LVN 1 then placed the contaminated medication tray on her medication cart. During an observation on 3/9/2026 at 4:38 p.m. in Resident 121's room, LVN 1 donned PPE and placed the contaminated medication tray on Resident 121's bedside table upon entrance to the room. Signage posted next to Resident 121's name indicated Resident 121 was on EBP. During an interview on 3/9/2026 at 4:40 p.m. with LVN 1, LVN 1 stated Resident 121 was placed on EBP because Resident 121 had a peripherally inserted central catheter (PICC- a tube inserted into a major vein above the heart) and wounds. LVN 1 acknowledged she did not disinfect the medication tray. LVN 1 stated I should have disinfect it to prevent cross-contamination (transfer of germs from one surface to another) of both carts (PPE and medication) and Resident 121's bedside table with C. difficile. During an interview on 3/12/2026 at 12:30 p.m. with the Director of Nursing (DON), the DON stated LVN 1 potentially spread C. difficile by cross contaminating multiple surfaces with the medication tray. The DON stated LVN 1 failed to follow infection control guidelines for C. difficile. During an interview on 3/12/2026 at 3:15 p.m. with the IP, the IP confirmed LVN 1's actions potentially caused the cross contamination of C. difficile and placed Resident 121 at risk for C. difficile infection. During a review of the facility's P&P titled Clostridioides (Clostridium) Difficile dated 12/2024, the P&P indicated, . Residents considered at high risk of developing symptoms associated with C difficile include .serious underlying illness . antibiotic [medicine to treat infections] .the primary reservoirs for C difficile are infected people and surfaces .Steps toward prevention and early intervention include .disinfection of items with potential fecal soiling . During a review of the facility's P&P titled Enhanced Barrier Precautions dated 2/2025, the P&P indicated, . Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention .for residents with wounds and/ or indwelling medical devices . indwelling medical devices include central lines [catheter] .		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Ombudsman (person who represents or protects the interest of another) was notified of resident transfer to the hospital for one of 18 residents (Resident 1) per Federal notification requirements. This failure had the potential to limit advocacy oversight and protection of Resident 1's rights during the transfer process. Findings:During a concurrent interview and record review on 3/12/26 at 9:08 a.m., with the MDS Coordinator (MDSC- a licensed nurse who manages the minimum data set [MDS]- a clinical assessment tool used to evaluate the health, functional status, and care needs of residents), the MDSC reviewed Resident 1's medical record. The MDSC stated Resident 1 was transferred to the hospital on [DATE] due to respiratory complications. The MDSC stated the record did not indicate the Ombudsman was notified of Resident 1's transfer to the hospital. During an interview on 3/12/26 at 9:26 a.m., with Social Services (SS), SS stated she was responsible for notifying the Ombudsman of resident transfers and discharges. SS stated her process was to notify the Ombudsman of all facility transfers and discharges on a monthly basis. SS stated notification of Resident 1's transfer to the hospital on [DATE] should have been recorded in Resident 1's medical record. During an interview on 3/12/26 at 3:30 p.m., with SS, SS stated the facility did not have a record of notifying the Ombudsman of Resident 1's transfer to the hospital in October 2025. During a review of the facility's policy and procedure (P&P) titled Transfer or Discharge Notice version 2.1, the P&P indicated, . Residents are permitted to stay in the facility and not be transferred or discharged unless . the transfer or discharge is necessary for the residents welfare and the residence needs cannot be met by the facility . The resident and representative are notified in writing of the following information . the specific reason for the transfer . The effective date of the transfer .the location to which the resident is being transferred . a copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer .		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a comprehensive person-centered care plan that included anticoagulation therapy (use of blood thinning medications) for one of 18 sampled residents (Resident 123). This failure had the potential to result in the lack of appropriate monitoring and increased the risk for bleeding complications for Resident 123. Findings: During review of Resident 123's admission Record (AR- a document that contains essential information about a resident), undated, the AR indicated Resident 123 was admitted to the facility on [DATE] with a primary diagnosis of cerebral infarction (disrupted blood flow to the brain due to blockage). During a review of Resident 123's Order Summary Report (OSR) dated 3/6/26, the OSR indicated, .Rivaroxaban [blood thinner] 20 mg [milligrams- unit of measure] Give 1 tablet by mouth one time a day for Atrial Fibrillation [irregular heartbeat]. The order included a black box warning (a serious safety warning given for drugs or drug classes that may cause serious harm or death). During a concurrent interview and record review on 3/12/26 at 12:03 p.m., with the Director of Nursing (DON), the DON reviewed Resident 123's medication orders and care plan. The DON confirmed the black box warning symbol indicated Rivaroxaban was a high-risk medication that could cause bleeding. The DON stated Resident 123's care plan did not address Resident 123's use of the high-risk medication and anticoagulation therapy. The DON stated it should have been care planned to help establish interventions to monitor and prevent bleeding with the goal of safe anticoagulation therapy for Resident 123. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person- Centered dated 3/2022, the P&P indicated, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the residents physical, psychosocial and functional needs is developed and implemented for each resident . The comprehensive, person-centered care plan . describes the services that are to be furnished to attain or maintain the residence highest practicable physical, mental, and psychosocial well-being .reflects currently recognized standards of practice for problem areas and conditions .		

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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 a care plan for Anticoagulant (medication that prevent or reduce the formation of blood clot) was reviewed and updated for one of five sampled residents (Resident 3). This failure had the potential to result in Resident 3 not receiving care that is aligned with his current needs. Findings: During a concurrent interview and record review on 3/12/2026 at 9:57 p.m. with the Director of Staff Development (DSD), Resident 3's physician's orders and care plan was reviewed. Resident 3's care plan indicated, . [Resident 3] is on Anticoagulant therapy (apixaban) . DSD stated, I am not seeing an order [Apixaban brand - a blood thinner used to reduce the risk of stroke] . Resident does not take [Apixaban brand] . He [Resident 3] has a care plan for [Apixaban brand] . He should not have that care plan anymore. DSD stated a medication use care plan should have been resolved once the resident was not on the medication anymore. DSD stated an updated care plan allowed for the residents' care to be current and appropriate. During an interview on 3/12/2026 at 2:38 p.m. with the Director of Nursing (DON), DON stated, The [Apixaban brand] care plan should have been resolved, care plan closed. Since resident [Resident 3] is not taking it anymore. DON stated the care plan should have been updated and current so staff could provide the appropriate care to the resident. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, . Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change .		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 106), received the necessary respiratory (the process of breathing) care (respiratory treatment/ therapy, oxygen therapy) and services with a current physician's order. This failure had a potential to result in respiratory complications for Resident 106. Findings: During a concurrent observation and interview on 3/9/2026 at 2:10 pm. with Resident 106 in her room, Resident 106 was lying in bed with head elevated. Resident 106 had a nasal cannula (NC) connected to an oxygen concentrator (a medical device that pulls ambient air and delivers pure oxygen) @ 4L/min (Liters per minute - unit of measure). Resident 106 stated she had been on oxygen therapy due to shortness of breath. During a concurrent observation and interview on 3/9/2026 at 3:45 pm. with Restorative Nursing Assistant (RNA) in Resident 106's room, RNA checked Resident 106's oxygen concentrator. RNA stated, It's [oxygen flow rate] at 4L/min. RNA stated Resident 106 had been on oxygen for some time. During a review of Resident 106's Minimum Data Set Assessment (MDS - a comprehensive assessment used for screening, clinical and functional status elements for nursing home residents), dated 12/23/2025, the MDS indicated, . Section O - Special Treatments . C1. Oxygen Therapy . b. While a Resident . [marked X] . During a review of Resident 106's Care Plan, dated 12/23/2025, the Care Plan indicated, . at risk for changes in respiratory status . O2 @ 3L/min via NC Continuously . Date Initiated: 08/20/2023 . During a concurrent observation, interview and record review on 3/11/2026 at 2:57 p.m. with Licensed Vocational Nurse (LVN) 2, in Resident 106's room. Resident 106 had oxygen via nasal cannula. LVN 2 stated, It's at 3L/min. Resident 106's Physician's Orders was reviewed. LVN 2 stated there was no order for oxygen therapy. LVN 2 stated there should have been an order since Resident 106 had been on oxygen for a long time. LVN 2 stated the physician order was needed to let staff know how much oxygen was safe to give to the resident. During an interview on 3/12/2026 at 2:35 p.m. with the Director of Nursing (DON), the DON stated there should have been an order for oxygen therapy for Resident 106. DON stated, So that we give the O2 rate as prescribed by the doctor, provide the proper care. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 10/2010, the P&P indicated, Verify that there is a physician's order . Review the resident's care plan to assess for any special needs of the resident .		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to document on the daily Census and Nursing Hour Posting the facility name, the total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses or licensed vocational nurses, and certified nurse aides. This failure resulted in the public not knowing the correct number of staff working per shift. During a concurrent interview and record review on 3/11/2026 at 2:20 p.m. with Director of Staff Development (DSD), the Census and Nursing Hour Posting, dated Wednesday, March 11, 2026 was reviewed. The census did not have the name of the facility or the correct number of staff or staffing hours for AM (morning shift), PM (afternoon shift), and NOC (night shift) shifts posted. DSD stated, the facility name is not on the posting, also the correct number of staff and hours for each shift (AM, PM & NOC) is not correct.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure two of 12 ointment medications in the treatment cart had pharmacy labels. This failure had the potential to result in the wrong medication ointment to be given to another resident. Findings: During a concurrent observation and interview on 3/11/2026 at 3:11 p.m. with Treatment Licensed Nurse (TLN) by the nurses' station hallway was a treatment cart. The second drawer contained ointment medications in clear bags with resident labels (pharmacy label). There were two tubes without labels. One medication was collagenase (brand) ointment (medication that helps remove dead tissue from a wound) 250 u/gm (units per gram - unit of measure) and the other one silver sulfadiazine (medication used to prevent and treat infections) Cream USP 1% 50 gm (grams - unit of measure). TLN stated, It [medications] is for residents. I don't see a resident label. I don't know whose it is. TLN stated the residents' ointments should have been labeled with a resident label. TLN stated medications without resident label could be used on a different resident. During an interview on 3/12/2026 at 2:26 p.m. with the Director of Nursing (DON), DON stated if the medication was resident specific it should have a pharmacy label. The DON stated an ointment medication without a resident label could be used on a different resident. During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2/2023, the P&P indicated, . Labelling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and accepted pharmaceutical practices . The medication label includes . medication name . resident's name .		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to ensure one unsampled resident's (Resident 70), Medication Administration Record (MAR) for Lacosamide (medication used to treat seizures) on 3/8/2026 was accurate. This failure resulted to an inaccurate clinical record and placed Resident 70 at risk for seizures. Findings: During a concurrent observation, interview and record review on 3/11/2026 at 2:42 p.m. with Licensed Vocational Nurse (LVN) 4 in the B-Wing Hallway, there was a medication cart with a locked drawer and on top of it was a Controlled Drug Record binder. Scheduled medications (medications with high potential for abuse and/or addiction) and antibiotics bubble packs (a form of tamper -evident packaging where an individual pushes individual sealed tablets through the foil to take the medication) were inside. There was a bubble pack of Lacosamide with nine tablets taken. The pharmacy label indicated one tablet to be taken twice a day (9am and 9pm). The record for Lacosamide was reviewed. The record indicated nine signatures for March 6th at 2100 (9pm, 2nd dose for the day) to March 11th at 2100. Only one dose was given on 3/8/2026 at 2100. LVN 4 stated the 9am dose for Lacosamide for Resident 70 was not given. Resident 70's MAR was reviewed. The MAR indicated on 3/8/2026, the Lacosamide was given to Resident 70 at 0900 (9am) and 2100. The 9am schedule was signed by LVN 5 but the medication was not given. During a concurrent interview and record review on 3/12/2026 at 9:05 a.m. with LVN 5, Resident 70's MAR was reviewed. The MAR indicated the 9 am and 9 pm doses on 3/8/2026 were given. LVN 5 stated the 9 am dose of the Lacosamide was not given to Resident 70. LVN 5 stated, It [MAR] is not accurate since only one [pm dose] was given. I do not remember why I did not get to give the medication and I signed it. LVN 5 stated the resident's clinical record should have accurately reflected what was given to the resident to be able to monitor the medication effectiveness. During an interview on 3/12/2026 at 2:34 p.m. with the Director of Nursing (DON), the DON stated the MAR should not have been signed if the medication was not given. The DON stated the MAR should accurately reflect if Resident 70 received or refused his medication for clinical record accuracy and resident safety. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated, . The individual administering the medication initials the resident's MAR on the appropriate line after giving the medication . During a review of the facility's policy and procedure (P&P) titled, Documentation Accuracy in the Health Record, dated 11/2023, the P&P indicated, . Clinical records should accurately reflect the care given by each member of the health care team . Accurate records are vital to the individual, and to the staff . serves as proof of work done .		