STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055573	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingsburg Center	1101 Stroud Ave Kingsburg, CA 93631

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that care and services were provided in accordance with the manufacturer's instructions for use for an air loss mattress (specialized medical mattress with internal air tubes and tiny holes that continuously circulate air to keep skin dry, cool, and reduce pressure, preventing bedsores (pressure ulcers) by shifting pressure points) and facility staff were trained and competent to use their air loss mattresses safely for one of two sampled residents (Resident (RES)) 2, when RES 2 who had a history of a recent fall (12/9/25) while on an air loss mattress at the facility. RES 2 weighed 124.4 pounds (lbs. -unit of weight measurement) and weight settings on the air loss mattress indicated weight was set at 245 -285 lbs. The nurses assigned to RES 2 did not know what pressure settings should be set on the air loss mattress, and there was no record of any training, education, in-service or competency record for air loss mattress use for the nurses.These failures had the potential to cause harm to RES 2 and other residents who used air loss mattresses and placed these residents at risk for skin breakdown due to pressure injury, pain, increased risk for falls and decline in physical functioning.During a review of RES 2's Physician Progress Note, dated 6/3/2025, the Physician Progress Note indicated RES 2 was a [AGE] year-old Male with an initial admission date of 9/28/24 and was readmitted to the facility on [DATE] for continuation of medical care. RES 2 had a past medical history of [Traumatic Brain Injury (TBI - damage to the brain from a sudden jolt, blow, or penetrating injury to the head, affecting brain function with mild to severe outcomes, ranging from temporary confusion to permanent disability or death)] [status post (after)] [Ventriculoperitoneal Shunt (VPS -Thin, flexible, plastic tube (called a catheter) that is placed under the skin to drain the extra fluid from brain and send it to belly to prevent high pressures inside brain)] placement, [high blood pressure], and venous thromboembolism (a serious condition involving a blood clot (thrombus) forming in a deep vein, most commonly in the legs). RES 2 was admitted to [Hospital A] on 05/22/2025 due to diaphoresis (sweating profusely), [shortness of breath] and [high blood pressure]. RES 2 underwent extensive workup and was sent to the facility for acute rehabilitation [high-intensity program designed to help people regain physical and thinking skills lost due to a severe injury, illness, or surgery]. During a concurrent interview and record review on 1/7/26 at 2:40 p.m. with the Nurse Unit Manager (NM), RES 2's medical record, undated was reviewed for recent falls. The NM stated RES 2 had a fall on 12/9/25 with no injuries. The NM stated RES 2 was currently on-an air loss mattress and she was unable to find the physician order for use of an air loss mattress for RES 2. The NM stated RES 2 was on an air loss mattress at the time of the fall on 12/9/25 and the facility review did not identify any issues with the settings or functionality of the air loss mattress at the time of the fall. The NM stated the Interdisciplinary Care Conference note dated 12/10/25 at 11:59 a.m. indicated . IDT investigated root cause: resident continues on air loss mattress, settings are correct and functioning well.During a concurrent observation and (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 1/7/26 at 3:00 p.m. in room RES-2's room with the NM, observed RES 2 on a bed with an air loss mattress. The NM validated the settings on mattress were set at a maximum weight of 285 pounds. The NM stated the air loss mattress was not set to the correct settings. NM stated RES 2 did not weigh 285 pounds. NM stated RES 2's weight on January 2, 2026, five days ago was 124.4 lbs. NM stated the air loss mattress should be set according to the resident's weight. NM stated the therapeutic effect would be affected by incorrect settings on the mattress and placed residents at risk for discomfort, pressure injuries to skin and falls from the bed. During a concurrent observation and interview on 1/7/25 at 3:16 p.m. with LVN 1 & the NM, observed RES 2's air loss mattress settings. LVN 1 stated she was assigned to RES 2 today. LVN 1 validated and stated the mattress settings were set at maximum settings of 285 lbs. LVN 1 stated she was unsure what the settings should be for RES 2. LVN 1 stated she would have to check physician orders for the settings. LVN 1 stated she was not sure what RES2's weight was but stated RES2 did not appear to be 245-285 lbs. LVN 1 stated nurses were expected to check that air loss mattresses were functioning properly each shift. During a concurrent interview and record review on 1/7/26 at 3:18 p.m. with LVN 1 & the NM, RES 2's medical records, undated were reviewed for the physician order for air loss mattress. LVN 1 stated that she was unable to find a physician's order for use of the air loss mattress and order for settings of the air loss mattress for RES 2. LVN 1 stated and validated the weight in the medical record and stated the most recent weight of RES 2 this week dated 1/2/26 was 124.4 lbs. LVN 1 stated that setting the wrong weight on the air loss mattress was not acceptable and have the potential to cause pressure injuries to skin and harm to the patient. LVN 1 stated that she was not aware that she should be checking the weight settings on the air loss mattress and going forward she will make sure air loss mattresses had the correct weight settings. LVN 1 stated as far as she was aware, use of an air loss mattress required a physician order. During an interview on 1/7/26 at 3:37 p.m. with the Director of Staffing Development (DSD), the DSD stated she was in charge of the staff training. The DSD stated she was familiar with RES 2. The DSD stated RES2 was on an air loss mattress and required two people to assist with turning and care. The DSD stated facility staff were trained on the use of air loss mattresses and it was important to have the correct weight setting on the air loss mattress. The DSD stated that 245-285 lbs. setting for a resident that only weighed 124.4 lbs. was not safe and was not aligned with instructions for use. The DSD stated incorrect weight-based settings may have the potential to cause harm to the patients. The DSD stated that Director of Nursing (DON) would be best to answer that question regarding weight settings and expectations for nursing staff training.During an interview on 1/7/26 at 3:53 p.m. with the ADM, the ADM stated he was familiar with RES 2. The ADM stated the fall on 12/9/25 for RES 2 was investigated as per facility policy, no injuries were identified, and RES 2's care plan was updated as needed. The ADM stated an air loss mattress use or settings on the air loss mattress were not identified as the cause for the fall. The ADM stated that he was not sure if the physician order was required for use of an air loss mattress and as far as he was aware, it was used as a nursing intervention. The ADM stated he would have to follow up and check with his clinical staff about the requirement for an order for the use of air loss mattress. The ADM stated RES 2 was on hospice care (a specialized, holistic support system for people with terminal illnesses, focusing on comfort, dignity, and quality of life when a cure is not possible, rather than curative treatment) and hospice nurse and physician was treating the patient. Requested to speak with director of nursing (DON) and ADM stated that DON is out on leave due to unforeseen circumstances. Requested training record for nurses assigned to RES 2 on the shift when fall occurred on 12/9/25 and LVN 1. The ADM stated he would have to follow up with his team and submit via email.During a phone (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 1/20/26 at 12:41 p.m. with the ADM, the ADM stated the facility did not have any policy for use of an air loss mattress and the facility staff were expected to follow manufacturer's instructions for use. The ADM stated he was made aware of the weight settings of 245-285 lbs. on RES 2's air loss mattress on 1/7/26 and agreed it was not set correctly. The ADM stated that the weight setting on the air loss mattress was not aligned with the instructions for use. The ADM stated he was not able to comment on whether setting an air loss mattress weight setting at 245-285 lbs. for a resident that weighs 124.4 lbs. had the potential to cause harm to the patient. The ADM stated he was unaware of any harm caused to RES 2 that were due to incorrect settings on the air loss mattress. The ADM stated the facility also did not have any training records for LVN 1 on the use of an air loss mattress or RN 1, nurse assigned to RES 2 on 12/9/25 when RES2 had a fall. The ADM stated the DON is not available for interview at this time and was still out on leave with a potential return date on [DATE]. The ADM stated the training for air loss mattress use could be beneficial but the facility at this time did not have a policy requiring training on the air loss mattress use or as an annual training requirement. During a phone interview on 1/20/26 at 3:33 p.m. with the DSD, the DSD stated she was in charge of education and in-services and training at the facility. The DSD stated that she worked with the DON and unit manager for nurse's training. The DSD stated and validated that she was unable to find any training or in-service record that indicated nurse [RN 1] assigned to RES 2 on 12/9/25 at the time of fall and LVN 1 assigned on 1/7/26 had received any in-service or training on air loss mattress use. The DSD stated the last in-services for air loss mattress was completed on 6/27/25 and 12/17/25 of last year. The DSD stated the in-service and training covered the settings on an air loss mattress and should be set according to the resident's weight . During a review of the air loss mattress's instruction for use provided by facility administrator (ADM), retrieved from https://vimeo.com/848769965, the instructions for use indicated . to prepare the mattress for the resident turn the dial to the correct weight of the resident . During a review of the document titled [model number], Low Air-Loss Mattress Replacement System With Alternating Pressure User's Manual, undated, provided by [company name] customer service, the document indicated . Intended Use Auto-pressure control Medical Air Mattress is designed for bed sore and wound care therapy treatment and prevention, which may occur during an extended hospital stay and nursing home/long term care environment . Warnings . refer to the manual before use and under proper medical supervision. Improper operation of this system may cause damage to the product and possible injury to the user . Do not use this product or any available optional equipment without first completely reading and understanding this instruction manual. If you are unable to understand the warnings, cautions or instructions, please contact a healthcare professional, dealer or authorized technician before attempting to use this equipment, otherwise injury or damage may occur. Only qualified personnel trained in the treatment and prevention of pressure injuries should operate this device . attention has to be paid to a potential danger that requires correct procedures or practices in order to prevent personal injury . Close supervision is necessary when this product is used by, on, or near children or persons with a disability .