

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER Shafter Nursing Care		STREET ADDRESS, CITY, STATE, ZIP CODE 140 East Tulare Avenue Shafter, CA 93263	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39763</p> <p>Based on interview and record review, the facility failed to ensure two of three sampled residents (Resident 2 and Resident 3) discharge care plans were developed. This failure had the potential for Resident 2 and Resident 3 to have unmet care needs upon discharge.</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record, (AR) the AR indicated, Resident 2 was admitted on [DATE] and discharged on [DATE].</p> <p>During a review of Resident 2's Multidisciplinary Care Conference, (MCC) dated 9/9/24, MCC indicated, (Resident 2) wishes to return to room and board when discharge is appropriate.</p> <p>During a review of Resident 3's AR, the AR indicated, Resident 3 was admitted on [DATE] and discharged on [DATE].</p> <p>During a review of Resident 3's MCC, dated 6/12/24, the MCC indicated, (Resident 3) wishes to ALF (assisted living facility) when discharge is appropriate.</p> <p>During a concurrent interview and record review on 10/2/24 at 12:34 p.m. with the Director of Nursing (DON), DON stated Discharges are a team effort, planning start on admission, each resident should have a care plan indicating the reason why they are here and how long they are going to stay, short or long term. Resident 2 ' s care plans were reviewed. DON confirmed Resident 2 did not have a discharge care plan. Resident 3 ' s care plans were reviewed. DON confirmed Resident 3 did not have a discharge care plan. DON stated she expects a discharge care plan to be completed once the MCC is completed.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Care Planning, revised 11/1/17, the P&P indicated, Purpose To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. II. The Care Plan serves as a course of action where the resident (resident ' s family and/or guardian or legally authorized representative), resident ' s Attending Physician, and IDT (Intradisciplinary Team) work to help the resident move toward resident-specific goals that address the resident ' s medical, nursing, mental and psychosocial needs. II. Each resident ' s Care Plan will describe the following: . E. Discharge plans as appropriate . III. The resident ' s preference and potential for future discharge.</p>

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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