STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056035	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shafter Nursing Care	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)
F 0656 Level of Harm - 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. 50409 Based on observation, interview, and record review, the facility failed to implement one of six sampled residents' (Resident 1) care plan (personalized plan of care outlining a person's needs and how they will be addressed) when the facility did not ensure Resident 1's room was well-lit and Resident 1 was wearing footwear (item of clothing that covers and protects the foot, including the soles of the feet) when walking. These failures resulted in Resident 1 sustaining a nondisplaced fracture (broken bone that did not move out of alignment) of the neck of the right femur (thigh bone) requiring open reduction and internal fixation (surgical procedure that treats severe bone fracture or dislocation by realigning the bones and stabilizing them with internal hardware [tools or devices used in medical procedures]). Findings: During a review of Resident 1's Admission Record (AR), dated 11/15/24, the AR indicated, Diagnosis. Spondylosis (age-related breakdown in the spine [backbone]) . Muscle Weakness (Generalized). Anemia (condition in which the body does not have enough healthy red blood cells that provide oxygen throughout the body) . Unsteadiness on Feet (difficulty walking or maintaining balance). During a review of Resident 1's Admission Minimum Data Set (MDS - an assessment tool), dated 9/24/24, the MDS indicated under Section GG (Functional Abilities and Goals) Resident 1's admission performance required substantial or maximal assistance (helper does more than half the effort) with putting on or taking off footwear. The MDS indicated walking was not attempted due to safety concerns (Resident 1 was not walking at the time of assessment). During a review of Resident 1's Care Plan (CP), dated 9/23/24, the CP indicated, (Resident 1) is high risk for falls related to generalized weakness, balance problems, decreased strength. Interventions. Footwear to prevent slipping when ambulating (walking). Keep environment well-lit. During a review of Resident 1's Clinical Health Status with Baseline Care Plan (CHSBCP), dated 9/23/24, the CHSBCP indicated Resident 1 had a score of 13 indicating he was high risk for falls. (continued on next page)

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

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's SBAR (Situation Background Appearance Review), dated 11/3/24, the SBAR indicated, Res (Resident 1) had a witnessed fall (someone had seen the fall) when attempting to sit on the edge of his bed; abrasion (scrape) to top of head, skin tear (cut) to R (right) elbow, and c/o (complained of) pain with AROM (assisted range of motion - assistance provided to move a part of the body through its full range of movement) to RLE (right lower extremity). During a review of Resident 1's Medication Administration Record (MAR), dated November 2024, the MAR indicated Resident 1 had a pain level of 3/10 (mild pain) on 11/3/24 at 3:05 a.m. (time of fall). During a review of Resident 1's RISK MANAGEMENT IDT (Interdisciplinary Team - group of professionals who assess, coordinate, and manage each resident's comprehensive needs [RMI]), dated 11/3/24, the RMI indicated, (Resident 1) is high risk for falls. He is alert and able to make needs known. Resident interviewed and stated, I (Resident 1) was getting out of the restroom and when I got out, I turned around (to sit on his bed) and my feet slipped. Xray (medical imaging technique that uses radiation to create a picture of the inside of the body) was completed. MD (Medical Director) orders to send out to ER (emergency room) for further eval (evaluation) and tx (treatment). During a review of Resident 1's Core Analytics Lab & Radiology Patient Report (CALRPR), dated 11/3/24, the CALRPR indicated, There appears to be an acute (severe and sudden in onset) nondisplaced right femoral (part of the thigh bone) neck fracture. During a review of Resident 1's SBAR Post Fall (SBARPF), dated 11/3/24, the SBARPF indicated, Prior to fall resident was: a. Ambulating (walking). Bare Feet. Environment. Dim lighting. Injury. Skin tear. VISION STATUS. Poor (with or without glasses) During a review of Resident 1's Nurses Note (NN), dated 11/6/24, the NN indicated, Recently sent out to (acute hospital) due to hip fracture to right side with admitting diagnosis of fracture of femoral neck (right), s/p (status post [condition after]) open reduction internal fixation. During a review of Resident 1's Documentation Survey Report (DSR - activities of daily living [basic personal tasks that people perform in their everyday lives] flowsheet), dated November 2024, the DSR indicated on 11/3/24 night shift, CNA 1 provided Resident 1 partial or moderate assist (helper does less than half the effort) with putting on or taking off footwear. During a concurrent observation and interview on 11/15/24 at 12:56 p.m. with Resident 1 in Resident 1's room, Resident 1 was not wearing footwear. Resident 1 stated he needed assistance when getting up and walking. Resident 1 stated, I couldn't do (walking) it myself. I'm scared of falling again. Resident 1 stated, I don't think I was (wearing footwear at the time of fall). During an interview on 11/18/24 at 4:13 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 11/3/24 she was guiding Resident 1 to the restroom at 2:40 in the morning. CNA 1 stated Resident 1 slipped and fell when she was assisting him back to bed. CNA 1 stated every time a staff would assist a resident to walk, the staff must make sure the resident wears a nonskid (designed to prevent slipping or skidding) footwear for safety. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/19/14 at 10:00 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, He (Resident 1) told me (11/3/24) when he was about to sit on the bed, when he turned, his legs flew under him. He was barefoot. LVN 1 stated it was dim in Resident 1's room and the overhead light was the only light on. LVN 1 stated Resident 1 was supposed to wear nonskid footwear whenever walking to prevent slipping. LVN 1 stated CNA 1 could not find Resident 1's nonskid footwear when Resident 1 was going to the restroom, but LVN 1 found Resident 1's nonskid footwear in Resident 1's room after the fall on 11/3/24. During an interview on 11/19/24 at 2:07 p.m. with Physical Therapy Assistant Rehabilitation Coordinator (PTARC - treats residents through exercise, massage, gait and balance training, and coordinates rehabilitation services for residents), PTARC stated Resident 1 was supposed to wear nonskid socks or nonskid footwear when walking to prevent slipping. During an interview on 11/19/24 at 2:33 p.m. with Director of Nursing (DON), DON stated Resident 1's cause of fall on 11/3/24 was Resident 1's feet slipped. DON stated Resident 1 was barefoot when he fell . During a review of the facility's policy and procedure (P&P) titled, Care Planning, dated 11/1/17, the P&P indicated, Purpose To ensure that a comprehensive person-center Care Plan is developed for each resident based on their individual assessed needs. The Care Plan serves as a course of action where the resident (resident's family and/or guardian or other legally authorized representative), resident's Attending Physician, and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs.