

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 02/10/2026
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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on interview and record review, the facility failed to provide one of three sampled residents (Resident 1) Responsible Party (RP) a written notice of the Notice of Medicare Non-Coverage (NOMNC-a notification letter stating Medicare will no longer pay for services) and ensure NOMNC notice was understood by RP. This resulted in Resident 1 being discharged without being given the right to appeal the NOMNC decision. Findings: During an interview on 2/17/26 at 8:24 a.m. with Resident 1's RP, RP stated on 12/23/25 at approximately 4 p.m. she received a phone call from Social Service Designee (SSD) stating Resident 1 was being discharged to a room and board (housing arrangements for adults). RP stated she did not fully understand the NOMNC notice and was not given the option to appeal the NMNC decision. RP stated, She (Resident 1) was being discharged . I just did what they told me, I didn't know. I didn't know I had options. During a concurrent interview and record review on 2/23/26 at 1:03 p.m. with SSD, Resident 1's NOMNC letter was reviewed. The NOMNC letter indicated Please sign below to indicate you received and understood this notice. No RP signature was noted on Signature of Patient Representative line. SSD stated on 12/23/25, Resident 1's RP was notified by phone of Residents 1's NOMNC notice. SSD stated option to appeal was not provided to RP. SSD stated, (RP) was not opposed to discharge, so it (appeal option) was not discussed with her. During a review of Resident 1's clinical record, a facility form titled, Optional Form to Document Alternate Delivery Notice of Medicare Non-Coverage, indicated Resident 1's RP was notified by phone on 12/23/25 at 4 p.m. regarding Resident 1's NOMNC notice. The form indicated, Document that representative verbalizes understanding of the information provided. During a concurrent interview and record review on 2/23/26 at 1:57 p.m. with SSD, SSD reviewed Resident 1's clinical record and was unable to provide documented evidence Resident 1's RP verbalized understanding of the NONMC notice.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 056035	If continuation sheet Page 1 of 1