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	12/19/2024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. 42744 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Informed Consent for eight of eight sampled residents (Resident 31, Resident 38, Resident 44, Resident 46, Resident 49, Resident 75, Resident 76, and Resident 286) receiving psychotherapeutic (affect thought, mood, perception, or behavior) drugs when the resident or resident's representative did not sign the VERIFICATION OF RESIDENT INFORMED CONSENT FOR PSYCHOTHERAPEUTIC DRUGS (California) (VRIC) form. This failure had the potential to result in questions regarding if informed consent had been obtained. Findings: During a review of Resident 31's VRICs, the VRICs for the following psychotherapeutic medications were found not to contain the resident or resident representative's signature: Clonazepam for anxiety (excessive feelings of worry, fear, or unease), dated 11/9/23; Seroquel for schizophrenia (chronic mental illness causing altered thought processes, perceptions, emotions, and social interactions), dated 9/5/24; Cymbalta for neuropathic (nerve) pain, dated 9/11/24; and Venlafaxine for major depressive disorder (persistent sadness), dated 4/1/24. During a review of Resident 44's VRICs, the VRICs for the following psychotherapeutic medications were found not to contain the resident or resident representative's signature: Duloxetine for major depressive disorder, dated 10/9/24; and Seroquel for Schizoaffective Disorder, dated 2/19/24. During a review of Resident 49's VRICs, the VRICs for the following psychotherapeutic medications were found not to contain the resident or resident representative's signature: Seroquel for Bipolar Disorder, dated 4/1/24; Depakote for Bipolar Disorder, dated 9/11/24; 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Paxil for Major Depressive Disorder, dated 7/1/24. During a review of Resident 76's VRICs, the VRICs for the following psychotropic medications were found not to contain the resident or resident representative's signature: Prozac for Depression, dated 9/11/24; Remeron for Depression, dated 9/11/24; and Cymbalta for Depression, dated 9/11/24. During a review of Resident 286's VRICs, the VRICs for the following psychotropic medications were found not to contain the resident or resident representative's signature: Depakote for Bipolar Disorder, dated 12/16/24; Trazadone for Major Depressive Disorder, dated 11/19/24; Olanzapine for Schizoaffective Disorder, dated 11/19/24; Buspirone for Anxiety Disorder, dated 11/19/24; and Venlafaxine for Major Depressive Disorder, dated 11/20/24. During a concurrent interview and record review on 12/17/24 at 4:06 p.m. with Director of Nursing (DON), Resident 46's VRICs were reviewed. The VRIC's for the following psychotropic medications were reviewed and found not to contain the resident's signature: Temazepam for insomnia (inability to sleep), dated 11/14/24; Lexapro for Major Depressive Disorder, dated 9/9/24; and Wellbutrin for Major Depressive Disorder, dated 9/11/24. DON stated the facility does not have the resident sign the VRIC forms. During a concurrent interview and record review on 12/18/24 at 10:21 a.m. with Minimum Data Set Nurse (MDSN), Resident 75's VRICs were reviewed. The VRICs for the following psychotherapeutic medications were found not to contain the resident or resident representative's signature: Buspirone for Anxiety, dated 3/15/24; Xanax 1 mg for Anxiety, dated 7/2/24; and Xanax 0.25 mg (milligram) for Anxiety, dated 9/27/24. MDSN stated there was no place on the VRIC form for the resident or their representative to sign and there was no place for a nurse to witness a resident signature. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 12/18/24 at 10:40 a.m. with MDSN, Resident 38's VRICs were reviewed. The VRICs for the following psychotherapeutic medications were found not to contain the resident or resident representative's signature: Buspirone for anxiety, dated 11/13/24; Depakote for Schizoaffective Disorder, Bipolar (extreme mood swings with changes in mood, behavior, ability to think, inability to sleep) type, dated 11/13/24; and Ziprasidone for Schizophrenia, Dated 11/13/24. MDSN stated the VRICs did not contain the resident or resident family member's signatures for consent. During a concurrent interview and record review on 12/18/24 at 2:09 p.m. with Administrator, the facility's policy and procedure (P&P) titled, Informed Consent, dated 11/30/2020, was reviewed. The P&P indicated, III. Obtaining Informed Consent A.i. An informed consent is required but not limited to, the administration of psychotherapeutic drugs . B. The resident or representative must sign an informed consent prior to administration of treatment/procedure. Administrator stated the facility was not following their P&P.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. 44134 Based on interview, and record review, the facility failed to ensure MDS (Minimum Data Set - assessment tool) quarterly (every three months) assessment was completed for one of 16 sampled residents (Resident 77). This failure had the potential for the delay in development and implementation of Resident 77's individualized care plan. Findings: During an interview on 12/19/24 at 11:45 a.m. with Minimum Data Set Nurse (MDSN), MDSN stated MDS assessments need to be completed on admission, quarterly, annually and at discharge. MDSN stated MDS assessments need to be completed within 14 days of the Assessment Reference Date (ARD-the specific end point of look-back periods in the MDS assessment process). During a concurrent interview and record review on 12/19/24 at 11:53 a.m. with MDSN, Resident 77's clinical record (CR), (undated) was reviewed. The CR indicated, Resident 77's admission MDS was completed on 7/30/24. MDSN stated Resident 77's quarterly MDS assessment had not been completed and was overdue. MDSN stated Resident 77's quarterly MDS should have been completed in October 2024. During a review of the facility's policy and procedure (P&P) titled, Resident Assessments, dated November 2019, the P&P indicated, 1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements.(2) Quarterly Assessments- Conduct not less frequently than (3) three months following the most recent.assessment of any type.2. A comprehensive assessment includes: a. completion of the Minimum Data Set (MDS).12. All resident assessments completed within the previous 15 months are maintained in the resident's active clinical record. The results of the assessment are used to develop, review and revise the residents comprehensive care plan.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 42744 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Pre-Admission Screening and Resident Review (PASRR) for two of two sampled residents (Resident 66 and Resident 38) with identified serious mental illness diagnoses when an updated PASRR Level 1 was not submitted. This failure had the potential for residents not to receive the specialized mental health services to meet their needs. Findings: During a review of Resident 66's History and Physical Reports (H&P) from General Acute Care Hospital (GACH), dated 1/22/24, the H&P indicated, Resident 66 had a history of Schizoaffective Disorder (a serious mental health condition with symptoms of hallucinations [seeing or hearing things that are not there]), delusion (false belief that is held even when presented with evidence that it is not true), depression (persistent sadness), and mania (abnormally elevated mood, energy, or activity), Anxiety (excessive feelings of worry, fear, or unease), and Suicidal behavior (threatening to harm or kill oneself). During a review of Resident 66's PASRR Level 1 screening from GACH, dated 1/23/24, the PASRR indicated, the screening was negative and indicated No to the question Does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis [mental health condition with loss of contact with reality], Delusions, and/or Mood Disturbance? During a concurrent interview and record review with Minimum Data Set (MDS- comprehensive standardized assessment of resident's functional capabilities and health needs) Nurse (MDSN), Resident 66's Diagnosis Report (DR), dated 12/17/24, and MDS Section I- Active Diagnoses, dated 11/19/24, were reviewed. The DR indicated Resident 66 had diagnoses of Schizophrenia (chronic mental illness causing altered thought processes, perceptions, emotions, and social interactions), Anxiety Disorder, and depression. The MDS indicated, Resident 66 had active diagnoses of Anxiety Disorder, Depression, and Schizophrenia. MDSN stated Resident 66's admitted was 1/24/24. MDSN stated when a new resident is admitted , she checks the PASRR Level 1 screening. MDSN stated she inputs the diagnoses into the MDS, but she does not have a process for checking the PASRR against the resident's diagnoses for accuracy. MDSN stated based on Resident 66's admitting diagnoses, she should have submitted a new PASRR Level 1 screening. 46958 During a review of Resident 38's Admission Record (AR), (undated), Resident 38 had a diagnosis of Schizophrenia (a mental illness that affects a person's thoughts, feelings and behaviors), Major Depressive disorder, Anxiety, Schizoaffective Disorder, Bipolar Type (mental health condition that causes extreme mood swings). (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 38's PASRR Level I Screening from GACH, dated 11/13/24, the PASRR indicated the screening was negative and indicated No to the question Does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis [mental health condition with loss of contact with reality], Delusions, and/or Mood Disturbance? During a concurrent interview and record review on 12/18/24 at 3:38 p.m. with Director of Nursing (DON), Resident 38's PASRR, dated 11/13/24 was reviewed. DON stated Resident 38 was readmitted to facility from hospital and had new diagnosis on 11/13/24 for Schizoaffective Disorder, Bipolar Type. DON stated PASRR Level I screening was completed by the GACH and had been filled out wrong. DON stated it is ultimately the facility's responsibility to make sure the PASRR is completed correctly with all current diagnosis. During a review of the facility's policy and procedure (P&P) titled, Pre-Admission Screening and Resident Review (PASRR), dated 7/1/23, the P&P indicated, Procedure.III.If the MDS does not match the PASRR Level 1 from the GACH or there is a significant change in the resident's mental or physical condition, the Facility is responsible for completing and new PASRR Level 1.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 46958 Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was scheduled and on duty eight hours a day, seven days a week. This failure had the potential for resident care to be negatively impacted. Findings: During a concurrent interview and record review on 12/17/24 at 11:05 a.m. with Director of Staff Development (DSD), the Nursing Staffing Assignment and Sign-in Sheet dated July 2024 were reviewed. The staff schedule indicated, there was no RN for 8 hours a day on 7/3/24, 7/4/24, 7/5/24, 7/6/24, 7/7/24, 7/8/24, 7/9/24, 7/10/24, 7/11/24, 7/12/24, 7/14/24, 7/15/24, 7/16/24, 7/17/24, 7/18/24, 7/19/24, 7/20/24, 7/21/24, 7/23/24, 7/25/24, 7/26/24, 7/27/24, 7/28/24, 7/29/24, 7/30/24, 7/31/24. DSD stated there was no RN present in the building for 8 hours a day on those days. During a concurrent interview and record review on 12/17/24 at 11:33 a.m. with DSD, the Nursing Staffing Assignment and Sign-in Sheet dated August 2024 was reviewed. The staff schedule indicated, there was no RN for 8 hours a day on 8/1/24, 8/6/24, 8/7/24, 8/8/24, 8/9/24, 8/10/24, 8/11/24, 8/12/24, 8/13/24, 8/14/24, 8/15/24, 8/17/24, 8/18/24, 8/19/24, 8/20/24, 8/21/24, 8/22/24, 8/23/24, 8/24/24, 8/25/24, 8/26/24, 8/27/24, 8/28/24, 8/29/24, 8/30/24, 8/31/24. DSD stated there was no RN present in the building for 8 hours a day on those days. During a concurrent interview and record review on 12/17/24 at 11:48 a.m. with DSD, the Nursing Staffing Assignment and Sign-in Sheet dated September 2024 was reviewed. The staff schedule indicated, there was no RN for 8 hours a day on 9/1/24, 9/2/24, 9/3/24, 9/4/24, 9/5/24, 9/6/24, 9/7/24, 9/8/24, 9/9/24, 9/10/24, 9/11/24, 9/12/24, 9/13/24, 9/14/24, 9/15/24, 9/16/24, 9/17/24, 9/18/24, 9/19/24, 9/20/24, 9/21/24, 9/22/24, 9/23/24, 9/24/24, 9/25/24, 9/26/24, 9/27/24, 9/28/24, 9/29/24, 9/30/24. DSD stated there was no RN present in the building for 8 hours a day on those days. During a concurrent interview and record review on 12/17/24 at 3:35 p.m. with DSD, the facility's policy and procedure (P&P) titled, RN Staffing Coverage Policy, dated 8/9/16 was reviewed. The P&P indicated, nursing homes have an RN onsite at least 8 consecutive hours per day, 7 days per week. DSD stated We don't meet the requirement for RN onsite at least 8 consecutive hours a day, 7 days a week. During a concurrent interview and record review on 12/18/24 at 7:38 a.m. with DSD, the Nursing Staffing Assignment and Sign-in Sheet dated October 2024 was reviewed. The staff schedule indicated, there was no RN for 8 hours a day on 10/1/24, 10/2/24, 10/3/24, 10/8/24, 10/9/24, 10/10/24, 10/12/24, 10/13/24, 10/14/24, 10/15/24, 10/16/24, 10/18/24, 10/19/24, 10/20/24, 10/21/24, 10/22/24, 10/25/24, 10/29/24, 10/30/24, 10/31/24. DSD stated there was no RN present in the building for 8 hours a day on these days. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 12/18/24 at 9:07 a.m. with DSD, the Nursing Staffing Assignment and Sign-in Sheet dated November 2024 was reviewed. The staff schedule indicated, there was no RN for 8 hours a day on 11/1/24, 11/2/24, 11/3/24, 11/4/24, 11/5/24, 11/6/24, 11/7/24, 11/8/24, 11/9/24, 11/11/24, 11/12/24, 11/13/24, 11/14/24, 11/15/24, 11/16/24, 11/18/24, 11/19/24, 11/21/24, 11/26/24, 11/27/24. DSD stated there was no RN present in the building for 8 hours a day on those days. During a concurrent interview and record review on 12/18/24 at 2:06 p.m. with DSD, facility's staff schedule dated December 2024 was reviewed. The staff scheduled indicated, there was no RN for 8 hours a day 12/3/24, 12/4/24, 12/5/24, 12/6/24, 12/8/24, 12/9/24, 12/10/24, 12/11/24, 12/12/24, 12/13/24, 12/14/24, 12/15/24 . DSD stated there was no RN present in the building for 8 hours a day on those days. During a review of the facility's P&P titled, RN Staffing Coverage Policy, dated 8/9/16, the P&P indicated, nursing homes have an RN onsite at least 8 consecutive hours per day, 7 days per week.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 46958 Based on interview and record review, the facility failed to ensure Performance Evaluation (PE-a process to give employees feedback on their job performance) for two of eight sampled employees (Certified Nursing Assistance [CNA] 3, CNA 4), were completed. This failure had the potential for the staff not be aware of their need for improvement in certain areas, which could affect patient care. Findings: During a concurrent interview and record review on 12/18/24 at 8:33 a.m. with Director of Staff Development (DSD), CNA 3's PE was reviewed. The PE indicated, CNA 3 was hired on 3/28/23 and there was no PE found in their employee file. DSD stated CNA 3's annual PE had not been completed. During a concurrent interview and record review on 12/18/24 at 8:55 a.m. with DSD, CNA 4's PE was reviewed. The PE indicated, CNA 4 was hired on 11/1/21 and there was no PE found in their employee file. DSD stated CNA 4's annual PE had not been completed. During a review of the facility's policy and procedure titled, Employee Performance Evaluation, (undated), the P&P indicated, To provide employees with the necessary feedback about job performance, employees will receive performance evaluations.Performance evaluations will be kept in the employee's personnel file.

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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. 42744 Based on observation, interview, and record review, the facility failed to: 1. Ensure food was dated and stored under sanitary conditions. 2. Ensure food was maintained at safe temperatures. These failures had the potential to result in residents getting food borne illnesses. Findings: 1. During a concurrent observation and interview on 12/16/24 at 9:15 a.m. with Dietary Supervisor (DS) in the kitchen, a container labeled peas was on the top shelf of Refrigerator #3 with an cracked/unsealed lid. DS stated the container of peas should have been sealed. During a concurrent observation and interview on 12/16/24 at 9:19 a.m. with DS at Refrigerator #5, an egg tray containing approximately two dozen eggs was open, uncovered, and undated. A carton of Liquid Pasteurized eggs was opened but without an open date. DS stated the egg tray should have been left in the original container and there was no way to determine the expiration date of the eggs. DS stated the carton of Liquid Pasteurized eggs was good for 7 days from the date it was opened but there was no open date. During a concurrent observation and interview on 12/16/24 at 9:20 a.m. with DS at Refrigerator #5, three trays of corn salad in small bowls were stacked on top each other. No date was observed on the trays or on the individual salad bowls. DS stated the corn salad bowls should have been dated. During a concurrent observation and interview on 12/16/24 at 9:22 a.m. with DS at Freezer #8, frozen broccoli was not sealed in the plastic bag. DS stated the broccoli should have been sealed. During a concurrent observation and interview on 12/16/24 at 9:24 a.m. with the DS in the dry storage room, a plastic bag containing elbow macaroni was not labeled or dated, and a container of nonfat dry milk was not sealed. DS stated they should have been dated and sealed. During a review of the facility's P&P titled, STORAGE OF FOOD AND SUPPLIES, dated 2023, the P&P indicated, 9. Dry food items which have been opened, such as pudding, gelatin, biscuit mix, pancake mix, dry cereal, spices, coffee, noodles, etc., will be tightly closed, labeled, and dated. During a review of the facility's P&P titled, Labeling and Dating of Foods, dated 2023, the P&P indicated, POLICY: All food items in the storeroom, refrigerator, and freezer need to be labeled and dated.Newly opened food items will need to be closed and labeled with an open date and used by date. 2. During an observation on 12/17/24 at 9:53 a.m. in the kitchen, three large metal trays covered with foil containing already baked lasagna were sitting on a shelf above the steam table. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/17/24 at 9:59 a.m. with [NAME] 1, [NAME] 1 stated the lasagna trays had come out of the oven approximately twenty minutes ago and were placed on the shelf above the steam table. During a concurrent observation and interview on 12/17/24 at 10 a.m. with Certified Dietary Manager (CDM) at the kitchen's steam table, the temperature of the lasagna in the three trays was taken by [NAME] 2. Lasagna Tray 1's food temperature was 127 degrees Fahrenheit (F-measurement of temperature), Lasagna Tray 2's food temperature was 143 degrees F, and Lasagna Tray 3's food temperature was 141 degrees F. CDM stated the food in Lasagna Tray 1 was not in the safe temperature range (140 F to 70 F). CDM stated the lasagna trays should not have been left on a shelf to cool off. During a concurrent observation and interview on 12/17/24 at 12:05 p.m. with DS, in the kitchen, peas were added to a resident's lunch plate during tray line. The temperature of the peas was not taken prior to plating and placing the plate in the dining cart. DS stated the temperature should have been taken prior to plating the food. During a review of the facility's P&P titled, COOLING AND REHEATING OF POTENTIALLY HAZARDOUS OR TIME/ TEMPERATURE CONTROL FOR SAFETY FOOD, dated 2023, the P&P indicated, POLICY: Cooked Potentially Hazardous Food (PHF) or Time/Temperature Control for Safety (TCS) food shall be cooled and reheated in a method to ensure food safety. PHF or TCS food include: . garlic . meat . pasta. PROCEDURE: When cooked PHF or TCS food will not be served right away it must be cooled as quickly as possible. The method is: THE TWO-STAGE METHOD Cool cooked food from 140 F to 70 F within two hours. 1) Previously cooked PHF or TCS food that will be hot-held should be rapidly reheated to an internal temperature of 165 F within two hours.