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	04/09/2026

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was 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 4/7/26 at 11:52 a.m. with Director of Staff Development (DSD), facility's Nursing Staffing Assignment and Sign-In Sheet (NSASS), dated January 2026 was reviewed. The NSASS indicated, there was no RN available to work in a consecutive 8 hour shift on 1/17/26 and 1/24/26. DSD stated there was no RN present in the building for 8 hours a day on 1/17/26 and 1/24/26.During a concurrent interview and record review on 4/7/26 at 11:54 a.m. with DSD, facility's NSASS, dated December 2025 was reviewed. The NSASS indicated, there was no RN available to work in a consecutive 8 hours shift on 12/24/25. DSD stated there was no RN present in the building for 8 hours a day on 12/24/25.During a review of the facility's policy and procedure (P&P) titled, RN Staffing Coverage Policy, dated 8/9/2016, the P&P indicated, F727 requires that nursing homes have an RN onsite at least 8 consecutive hours a day, 7 days a week.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately complete the quarterly Minimum Data Set (MDS-part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. A comprehensive assessment of each resident's functional capabilities is completed) assessment for one of 44 sampled residents (Resident 10). This failure had the potential for Resident 10 to not receive the appropriate required services. Findings:During a review of Resident 10's MDS assessment, dated 3/9/26, the MDS indicated, Section I- Active diagnoses in the last 7 days included Depression (a common, serious medical illness that causes persistent sadness, loss of interest in activities, and a range of physical and emotional symptoms) and Schizophrenia (causing psychosis (hallucinations/delusions), disorganized thinking, and emotional disconnection from reality).During a review of Resident 10's Diagnosis Information (DI), dated 3/9/26, the DI indicated Resident 10 did not have documentation of a diagnosis of Depression or Schizophrenia.During a concurrent interview and record review on 4/9/26 at 9:35 a.m. with Minimum Data Set Coordinator (MDSC), Resident 10's MDS section I active diagnosis (MDS), assessment dated [DATE], was reviewed. The MDS indicated Resident 10 had an active diagnosis of Depression and Schizophrenia. MDSC stated Resident 10 does not have an active diagnosis of depression or Schizophrenia and Resident 10 is not taking medication for depression of schizophrenia. MDSC stated she did not complete the assessment accurately and she should have reviewed it before submitting. During a review of the facility's policy and procedure (P&P) titled, Resident Assessments, dated 2019, the P&P indicated, The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments.All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to ensure meal preferences were honored for one of 25 sampled residents (Resident 82). This failure had the potential for nutritional needs not to be met for Resident 82. Findings:During a review of Resident 82's Meal Ticket (MT), dated 4/7/26, the MT indicated, Resident 82 dislikes Spinach.During a concurrent observation and interview on 4/7/26 at 11:22 a.m. with Dietary Aide (DA) 1, in the kitchen, DA 1 was checking Resident 82's lunch tray during tray line. Resident 82's lunch tray contained Meatballs and Gravy, Penne pasta with Garlic & Herbs, Zesty Spinach, Fresh [NAME] Salad, and Chocolate Cake. DA 1 stated Resident 82's tray was ready to be delivered to Resident 82. During a concurrent interview and record review on 4/7/26 at 11:23 a.m. with DA 1 in the kitchen, Resident's 82's MT dated 4/7/26 was reviewed. The MT indicated, Resident 82 dislikes Spinach. DA 1 stated she had not noticed the tray had Spinach on it. DA 1 stated she should have caught it and should have removed the spinach from the tray since the Resident 82 did not like it. During a review of the facility's policy and procedure (P&P) titled, Food Preferences, dated 2023, the P&P indicated, Resident's food preferences will be adhered to within reason. Substitutes for all food disliked will be given from the appropriate food group.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to implement effective infection control practices when:Hand hygiene was not provided for two of three sampled residents (Resident 19 and Resident 86) before residents were given their lunch tray. This failure had the potential to spread infection to residents.Dress Code policy was not followed by one of two sampled cooks (Cook 1) in the kitchen. This failure had the potential for food contamination.Findings: 1.During a review of Resident 19's BIMS (Brief Interview of Mental status), dated 1/17/26, the BIMS indicated Resident 19's score was 15 (cognitively intact). During a concurrent observation and interview with Resident 19 in Resident 19's room, Resident 19 was sitting up in bed eating his lunch. Resident 19 was asked if the Certified Nursing Assistant (CNA) had offered hand hygiene. Resident 19 stated he had not received hand hygiene and would like to have his hands cleaned. During an interview on 4/6/26 at 11:53 a.m. CNA 1 was asked if she had provided hand hygiene to Resident 19. CNA 1 stated she had not provided hand hygiene and stated she have offered. During a concurrent observation and interview on 4/6/26 at 11:58 a.m. in Resident 86's room, CNA 1 delivered Resident 86's lunch tray. CNA 1 was asked if she had provided hand hygiene to Resident 86 before giving him his lunch tray. CNA 1 stated she had not provided hand hygiene and stated she should have offered. During a review of the facility's policy and procedure (P&P) titled, Hand Hygiene During Mealtime, dated 2024, the P&P indicated, Hand hygiene is offered to all residents prior to meal tray service. Staff must ensure residents clean their hands before trays are passed or meals are served. 2. During a concurrent observation and interview on 4/7/26 at 11:17 a.m. in the kitchen with [NAME] 1, [NAME] 1 had a beard that was not covered with a beard restraint. [NAME] 1 was uncovering the food to check the temperature. [NAME] 1 stated he should have been wearing a beard restraint while he was in the kitchen. During an interview on 4/8/26 at 2:20 p.m. with Certified Dietary Manager (CDM), CDM stated the cook should have been wearing a beard restraint and stated it was her expectation for all staff that are in the kitchen to use a hair or beard restraint. During a review of the facility's policy and procedure (P&P) titled, DRESS CODE, dated 2023, the P&P indicated, If applicable, beards and mustaches (any facial hair) must wear beard restraint.