STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555861	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Oaks Care	897 North M Street Tulare, CA 93274

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 38993 Based on interview and record review, the facility failed to ensure the abuse policy was implemented for two of five sampled residents (Resident 4 and Resident 5) when an abuse allegation was not reported to the management by a staff member (Licensed Vocational Nurse - LVN 1). This failure had the potential for delayed investigation and place other residents at risk for abuse. Findings: During an interview on 6/5/24 at 12:14 p.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated on 5/30/24, Resident 1 reported (to LVN 1) Resident 4 and Resident 5 were afraid of Certified Nursing Assistant (CNA) 2 because she (CNA 2) had hit or yelled at Resident 4, and she was loud or mean to Resident 5. LVN 1 stated when Resident 1 reported the allegations she did not report it to the management because Resident 1 stated she already reported the allegations to the Director of Nursing (DON). LVN 1 stated she would talk to the DON about the allegations when she returned to work on 6/5/24 (6 days later). LVN 1 stated she should have reported the allegations to the management. During an interview on 6/5/24 at 12:48 p.m. with the Assistant Director of Nursing (ADON), the ADON stated when there was an allegation of abuse reported to a staff member the staff member was expected to report the allegation right away. During an interview on 6/12/24 at 12:23 p.m. with Administrator, Administrator stated when there was an allegation of abuse the staff was expected to ensure the safety of the resident and report the allegation (to management). During a review of the facility's policy and procedure (P&P) titled Abuse, Neglect and Exploitation dated 2023, the P&P indicated, Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes.immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38993 Based on observation, interview, and record review, the facility failed to ensure the food was served at the proper temperature for two of three sampled residents (Resident 6 and Resident 7). This failure resulted in Resident 6 and Resident 7 being served food at an unappetizing temperature. Findings: During a concurrent observation and interview on 6/20/24 at 7:16 a.m. with Resident 5 in Resident 5's room, Resident 5 had a waffle, a slice of toast, a sausage patty, milk, and juice on his breakfast tray. Resident 5 stated the waffle, toast and sausage patty were lukewarm and not hot. During a concurrent observation and interview, on 6/20/24 at 7:20 a.m. with Resident 6, in Resident 6's room, Resident 6 had a slice of French toast, oatmeal and sausage on her breakfast tray. Resident 6 stated the breakfast was cold, and the oatmeal was always cold. Resident 6 stated she would prefer the food to be hotter. During a concurrent observation and interview on 6/20/24 at 7:38 a.m. with Dietary Supervisor (DS), in the hallway. A breakfast tray was taken off the meal cart and the temperature was taken of the sausage patty, French toast, milk and juice. The food temperatures were the following: Sausage Patty 108.6 F (Fahrenheit-unit of measurement) .French Toast 101.3 F .milk 59.8 F .Cranberry juice 61.6 F . During an interview on 6/20/24 at 7:53 a.m. with DS, DS stated the milk should have been at least 45 F , the waffle and the French toast should have been at least 120 F , and the sausage should have been at least 120 F . During a review of the facility's policy and procedure (P&P) titled, Meal Service dated 2023, the P&P indicated, Recommended Temp (temperature) at Delivery to Resident.Milk/Cold Beverage . = (less than) 45 F .Hot Entree = (greater than) 120 F .Waffles/Pancakes, French Toast.= 120 F .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 38993 Based on observation, interview, and record review, the facility failed to ensure four of five sampled staff (Certified Nursing Assistant - CNA 1, CNA 3, CNA 4, and CNA 5) were wearing name tags. This failure resulted in residents and visitors being unaware of who was providing care. Findings: During an interview on 6/5/24 at 9:03 a.m. with Family Member 1 (FM 1), FM 1 stated she was unable to identify the staff because they usually do not have name tags on. During an interview on 6/5/24 at 11:02 a.m. with Resident 1, Resident 1 stated she was unable to identify staff because they do not wear name tags. During a concurrent observation and interview on 6/5/24 at 1:37 p.m. with CNA 1, CNA 1 was observed going in and out of residents' rooms assisting residents. CNA 1 was not wearing a name tag. CNA 1 stated she did not have a name tag on because she misplaced it and had not requested a new one. CNA 1 stated she should have a name tag on. During an interview on 6/5/24 at 1:02 p.m. with Director of Staff Development (DSD), DSD stated all staff were expected to wear a name tag. During a concurrent observation and interview on 6/20/24 at 6:40 a.m. with CNA 3, CNA 3 was not wearing a name tag. CNA 3 stated she should be wearing her name tag, but she forgot it. During a concurrent observation and interview on 6/20/24 at 6:41 a.m. with CNA 4, CNA 4 was not wearing a name tag. CNA 4 stated she should be wearing her name tag, but she forgot it. During a concurrent observation and interview on 6/20/24 at 6:45 a.m. with CNA 5, CNA 5 was not wearing a name tag. CNA 5 stated he should have been wearing a name tag, but he had lost it. During a review of the facility's policy and procedure (P&P) titled, Identification Badges dated 2023, the P&P indicated, 1. All employees are required to wear an identification badge during their hours worked 2. All badges must be clearly visible and contain the employee's first name, last name, and job title.