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	02/12/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to implement effective infection control practices for five of 22 sampled residents (Resident 82, Resident 36, Resident 19, Resident 62, and Resident 32) when staff did not provide hand hygiene before eating. This failure had the potential to spread infection to residents. Findings: During a concurrent observation and interview on 2/9/26 at 11:57 a.m. with Certified Nursing Assistant (CNA) 5, in the hallway outside of Resident 82's room. CNA 5 handed Resident 82 her lunch tray, CNA 5 stated, she did not provide hand hygiene to Resident 82 and stated she should have provided hand hygiene to the resident. During a concurrent observation and interview on 2/9/26 at 11:59 a.m. outside Resident 82's room, Resident 82 was eating her lunch. Resident 82 stated she was not provided hand hygiene prior to receiving her lunch. Resident 82 stated she would have liked for her hands to be cleaned. During a review of Resident 82's Brief Interview for Mental Status ([BIMS], a screening tool used in long term care to evaluate cognitive function.13-15 points: cognitively intact; 8-12 points: moderate cognitive impairment; 0-7 points: severe cognitive impairment), dated 11/11/25, the BIMS score was 11. During a concurrent observation and interview on 2/9/26 at 12:05 p.m. in Resident 36's room, Resident 36 was eating her lunch. Resident 36 stated staff did not provide hand hygiene before serving her meal. Resident 36 stated sometimes they do give me a wash cloth or wipe but not today Resident 36 stated she would like to clean her hands before each meal. During a concurrent observation and interview on 2/9/26 at 12:16 p.m. in Resident 19's room, Resident 19 was eating her lunch using her hands. Resident 19 stated staff did not provide her hand hygiene before her meal was served. Resident 19 stated she used tissue paper that she had found on her bedside table to wipe her hands before she started eating. Resident 19 stated she would like to be able to clean her hands before she eats. During a review of Resident 19's BIMS the indicated, BIMS Summary Score 12. During a concurrent observation and interview on 2/9/26 at 12:17 p.m. in Resident 62's room, Resident 62 was eating her for lunch. Resident 62 stated staff did not provide hand hygiene before serving her meal and stated she sometimes she askes for assistance. During a review of Resident 62's BIMS, dated 1/22/26, the BIMS indicated, BIMS Summary Score 15. During a concurrent observation and interview on 2/9/26 at 12:28 p.m. in Resident 32's room, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 32 was eating a salad for lunch. Resident 32 stated staff did not provide hand hygiene before serving her meal. Resident 32 stated sometime her meal tray will have a wipe she can use to wash her hands. Resident 32 stated, I guess it's when they feel like it. Resident 32 stated she would like to clean her hands before each meal. During a review of Resident 32's BIMS, dated 1/12/26, the BIMS indicated, BIMS Summary Score 15. During a review of the facility's policy and procedure (P&P) titled, Serving a Meal, dated 2026, the P&P indicated, 1. Prepare the room or serving area for mealtime (decrease noise level, provide lighting position comfortably) and make sure hands and face are clean.

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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 0656 Level of Harm - Minimal harm or potential for 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. Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled, Comprehensive Care Plans, for two of 12 sampled residents (Resident 31 and Resident 101). This failure had the potential to not meet residents' physical, psychosocial (related to thought or behavior), and functional needs. Findings: During an observation on 2/9/26 at 10:49 a.m. in Resident 31's room, Resident 31 had a one-to-one (one staff assigned to monitor one resident only) staff member monitoring the resident. During an interview on 2/11/26 at 9:52 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she does not know the reason Resident 31 is on one-to-one monitoring. During an interview on 2/11/26 at 9:56 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 31 is being monitored for falls. CNA 2 stated she started one-to-one monitoring a month ago with Resident 31. During a concurrent interview and record review on 2/11/26 at 4:21 p.m. with Director of Nursing (DON), Resident 31's Care Plan, (CP) (undated) was reviewed. The CP indicated no goals or interventions for one-to-one monitoring. DON stated the one-to-one monitoring was for behaviors and it should have been care planned. During a review of Resident 31's Order Summary Report,(OSR) dated 1/31/26, the OS indicated, Monitor 1:1 every shift. During a review of Resident 101's OSR, dated 2/11/26, the OSR indicated, Admit to HOSPICE [end of life care] care effective 2/7/26. Admit Resident to [Hospice Care Agency], .with any change in condition and/or any change in medication or refill. During a concurrent interview and record review on 2/11/26 at 2:20 p.m. with DON, DON reviewed the electronic medical record (eMAR) for Resident 101's care plan for Hospice Care/End of life Care. DON reviewed all the care plans in the eMAR for Resident 101 and was unable to provide documented evidence a care plan for Hospice Care/End of life Care was developed. DON stated, He [Resident 101] was picked up [admitted to hospice care]. DON was unable to find a hospice care plan and stated, it should have been implemented [referring to care plan]. During a review of the facility's P&P titled, Comprehensive Care Plan, dated 2025, the P&P indicated, Policy: It is the policy of this facility to develop and implement a comprehensive-person centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframe to meet a resident's medical, nursing, and mental and psychosocial needs and All services that are identified in resident's comprehensive assessment and meet professional standards of quality . Professional standards of quality means that care and all services are provided according to accepted standard of clinical practice. Standard may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting . Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care all (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality, and incorporate culturally competent and trauma-informed care as indicated.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to: 1. Ensure one of three sampled resident's (Resident 1) medical record contained accurate documentation. This failure had the potential to result in delayed treatment for the resident who was returning from hemodialysis (dialysis, life sustaining medical treatment that uses a machine to filter waste, toxins and excess fluid from the blood when kidneys are unable to function properly).2. Ensure one of one sampled resident's (Resident 10) physicians order for oxygen administration was followed as ordered. This failure had the potential to result in low oxygen saturation levels for Resident 10.3. Ensure one of two sampled residents (Resident 58) had an emergency dialysis kit at bedside. This failure had the potential for staff not to properly treat Resident 58 in the event of an emergency. Findings: 1.During an observation on 2/9/26 at 3:09 p.m. at the nurse's station, Resident 1 arrived by medical transport to the facility and was in a wheelchair. Transportation staff placed Resident 1 in her wheelchair next to the nurse's station. During an observation on 2/9/26 from 3:12 p.m. to 3:41 p.m., no staff entered Resident 1's room to assess or obtain vital signs ([VS], used to assess physical well-being, monitor health status and detect a medical problem using body temperature, heart rate, breathing rate, and blood pressure). During a concurrent interview and record review on 2/11/26 at 11:47 a.m. with Director of Nursing (DON), Resident 1's Nurses Dialysis Communication Record (NDCR), dated 2/9/26, indicated, Post-Dialysis Monitoring: RETURNED TO UNIT AT: 1420 [2:20 p.m.]. DON stated Resident 1's NDCR was signed by Licensed Vocational Nurse (LVN) 1. DON was informed that LVN 1 would not have been able to complete the post dialysis monitoring at this time because Resident 1 had not returned to the facility from dialysis until 3:09 p.m. DON stated she was unsure of what happened. DON stated all assessments should be documented when completed with the correct date and time. During an interview on 2/11/26 at 2:12 p.m. with DON, DON stated LVN 1 had informed her that LVN 1 had accidentally charted Resident 1's Post- Dialysis Monitoring assessment at the wrong time, and stated she had assessed Resident 1 at 3:20 p.m. and not at 2:20 p.m. DON was informed that the statement from LVN 1 was inaccurate as State Auditor (SA) had observed Resident 1 on 2/9/26 from 3:12 p.m. to 3:41 p.m. and no assessment or VS were completed. DON did not respond. During a concurrent interview and record review on 2/11/26 at 2:46 p.m. with LVN 1, Resident 1's NDCR, dated 2/9/26 was reviewed. the NDCR indicated, Post-Dialysis Monitoring: RETURNED TO UNIT AT: 1420. LVN 1 stated she worked on 2/9/26. LVN 1 stated she normally works from 6:30 a.m. to 3 p.m. but on 2/9/26 she stayed until 4:44 p.m. to complete her charting. LVN 1 stated she was charting at the nurse's station and LVN 3 gave her a paper with Resident 1's VS. LVN 1 stated LVN 3 had asked her to chart Resident 1's assessment in Resident 1's NDCR. LVN 3 informed LVN 1 that Resident 1's assessment was not completed when she came back and that it was about an hour late. LVN 1 stated she did not take Resident 1's VS or complete her assessment on 2/9/26. LVN 1 stated she did not know what time Resident 1's VS and assessment were completed. LVN 1 stated she should not have documented LVN 3's assessment of Resident 1. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated July 2017, the P&P indicated, All services provided to the resident.shall be documented in the resident's medical record.Documentation in the medical record will be objective.complete, and accurate.Entries may only be recorded in the residents clinic [clinical record] by the licensed (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	personnel.in accordance with state law and facility policy. 2. During a concurrent interview and observation on 2/9/26 at 11:06 a.m., inside Resident 10's shared bedroom, Resident 10 was in bed, with nasal canula (device carry oxygen for respiratory care) tubing around both ears and resting under the nose. Resident 10 stated she was receiving 2 liters (unit of measurement) of oxygen [oxygen gas]. Resident 10's oxygen concentrator (machine used to deliver oxygen) was noted at the bedside and the concentrator gauge indicated the oxygen delivery amount to be 3 liters. During a concurrent observation and interview on 2/9/26 at 11:40 a.m. with Licensed Vocational Nurse (LVN) 1, inside Resident 10's bedroom, LVN 1 examined the oxygen concentrator at Resident 10's bedside, LVN 1 stated the oxygen concentrator had been running at 3 liters per the concentrator gauge. During a review of Resident 10's Order Summary Report (OSR), dated 2/9/26, the OSR indicated, OXY [Oxygen]: Monitor O2 [Oxygen] Sats [saturation – amount of oxygen in the blood] every Shift. Goal to maintain O2 Stats [saturation] Greater Than 90%, every shift for PLEURAL EFFUSION [is abnormal accumulation of excess fluid in the pleural space, the thin, fluid-filled area between the lungs and the chest cavity wall, can cause significate quality of life impairment], life related to PLEURAL EFFUSION . Oxygen @(at) 2 L [liters]/min [minute] via [delivery through] nasal cannula continuously every shift related to PERSONAL HISTORY OF COVID-19 [respiratory infection affecting the lungs]. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 2010, the P&P indicated, Purpose The purpose of this procedure is to provide guidelines for safe oxygen administration Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident . Assessment Before administering oxygen, and while the resident is receiving oxygen therapy. 3. During a concurrent observation and interview on 2/11/26 at 10:04 a.m. with LVN 2, in Resident 58's room no dialysis emergency kit (emergency kit containing gloves, gauze, tape, torniquet and clamp) was available for use. LVN 2 was unable to locate the emergency kit in Resident 58's room. LVN 2 stated the kit is usually hanging on the wall behind the residents bed. During a concurrent observation and interview on 2/11/26 at 10:11 a.m. with LVN 4, in Resident 58's room no dialysis emergency kit hanging above A or B bed. LVN 4 stated she did not see the emergency kit. LVN 4 stated Resident 58 was moved from A bed to B bed and did not see the emergency kit hanging above either bed area's. LVN 4 Resident 58 should have an emergency kit in her room. During a review of Order Summary, (OS) dated 1/27/26, the OS indicated, Ensure Emergency Kit is placed at bedside (Gloves, Gauze, Tape, Torniquet, and clamp) every shift for Hemodialysis every shift. During a review of the facility's P &P titled, Comprehensive Care Plans, dated 2025 Revisions, the P & P indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident . and timeframes to meet a resident's medical . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychological needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure one of three sampled resident (Resident 1) had a post (after) hemodialysis (dialysis, life sustaining medical treatment that uses a machine to filter waste, toxins and excess fluid from the blood when kidneys are unable to function properly) assessment after returning to the facility. This failure had the potential for post dialysis complications and side effects (bleeding from dialysis access site, pain, low blood pressure, nausea/vomiting) to go unnoticed and untreated.Findings:During a review of Resident 1's Order Summary Report (OSR), dated 10/8/25, the OSR indicated, Dialysis.at [dialysis centers name].every day shift.Mon [Monday], Wed [Wednesday], Fri [Friday] for hemodialysis.During a concurrent observation and interview on 2/9/26 at 10:26 a.m. with Director of Staff Development (DSD) outside of Resident 1's room, Resident 1 was not in the room. DSD stated Resident 1 was at the dialysis center receiving dialysis.During an observation on 2/9/26 at 3:09 p.m. at the nurse's station, Resident 1 arrived by medical transport to the facility and was in a wheelchair. Transportation staff placed Resident 1 in her wheelchair next to the nurse's station. Resident 1 placed a white dialysis communication binder on the nurse's station counter. Resident 1 requested to make a phone call.During an observation on 2/9/26 p.m. at 3:12 p.m. at the nurse's station, Resident 1 ended her phone call and informed staff she wanted to go to her room. Staff then took Resident 1 to her room.During an observation on 2/9/26 from 3:12 p.m. to 3:41 p.m., no staff entered Resident 1's room to assess or obtain vital signs (VS, used to assess physical well-being, monitor health status and detect a medical problem using body temperature, heart rate, breathing rate, and blood pressure).During an observation on 2/9/26 at 3:48 p.m. in the hallway outside of Resident 1's room, a staff member took the VS monitor into another resident room. No staff entered Resident 1's room to assess or obtain VS.During an observation on 2/9/26 at 3:52 p.m. in the hallway outside of Resident 1's room, a staff member pushed the VS machine in the direction of another hallway in the facility. No staff entered Resident 1's room to assess or obtain VS.During an interview on 2/9/26 at 3:57 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she checks residents' VS at the start of her shift (2:30 p.m.), and when the nurse requests. CNA 1 stated she had not obtained Resident 1's VS since the resident returned back to the facility from the dialysis center.During an observation on 2/9/26 at 3:59 p.m. in the hallway outside of Resident 1's room, no staff entered Resident 1's room to assess or obtain VS since she had returned back to the facility from the dialysis center.During an observation and interview on 2/9/26 at 4:01 p.m. in the hallway on the 400 wing, Licensed Vocational Nurse (LVN) 3 was standing next to a medication cart. LVN 3 stated he was starting to pass medications to his residents. LVN 3 stated he was aware that Resident 1 had returned to the facility from the dialysis center. LVN 3 stated residents should be assessed as soon as they return from the dialysis center. LVN 3 stated he had not completed Resident 1's post dialysis assessment. LVN 3 stated Resident 1 should have been assessed as soon as she returned from the dialysis center.During an interview on 2/11/26 at 9:34 a.m. with Registered Nurse (RN) 1, RN 1 stated residents that receive dialysis treatments should be assessed and VS obtained upon arrival back to the facility. RN 1 stated the assessment should consist of monitoring for pain and ensuring the resident was not in any distress. RN 1 stated there should have been a visual assessment of the dialysis access site to ensure the dressing was intact and that there was no bleeding. RN 1 stated post dialysis assessments are completed by either an RN or LVN.During an interview on 2/11/26 at 11:47 a.m. with Director of Nursing (DON), DON stated it was her expectation that Resident 1's nurse would assess the dialysis access site, assess for any pain and obtain VS, as soon as Resident 1 arrived back at the facility.During a review of the facility's policy and procedure (P&P) titled, Hemodialysis Catheters-Access and Care of, dated February 2023, the P&P indicted, Care Immediately Following Dialysis Treatment.If there is major bleeding from the site (post-dialysis), apply pressure to insertion site and contact emergency services and dialysis center. Notify MD. The nurse should document in the (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's medical record.1. Location of dialysis location site.any part of report from dialysis nurse post- dialysis.Observations post-dialysis.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications and chemical cleaning/disinfecting agents were stored separate in one of two medication carts. This failure had the potential to result in cross contamination of stored medications and chemical cleaning/ disinfecting agents.Findings:During a concurrent observation and interview on 2/11/26 at 8:26 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 was opening the 300 medication cart bottom right drawer. The following was noted inside the medication cart: the drawer divided into three sections, the first section contained an opened/used container of Sani disinfectant wipes and 11 medication bubble packets, the second section contained an opened/used container of Sani wipes bleach, and the third section contained 12 medication bubble packets. LVN 2 stated, the containers of Sani wipes [Sani disinfectant wipes and Sani Bleach wipes] should be stored on one side and the medication should be stored on the other side. LVN 2 stated they should not be stored together. During a review of the facility's policy and procedure (P&P) titled, Medication Storage, dated 2007, the P&P indicated, 4.1 STORAGE OF MEDICATION Policy Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration . 9. Potentially harmful substances (such as urine test reagents tablets, household poisons, cleaning supplies, disinfectants) are clearly identified and stored in an area separate from medications.

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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. During an observation, interview, and record review, the facility failed to ensure one of two cooks (Cook 2) followed its DRESS CODE policy and procedures (P&P), when [NAME] 2 did not have a beard cover. This failure had the potential for food contamination. Findings: During an observation on 2/10/26 at 12:13 p.m. in the kitchen, [NAME] 2 had a full beard on his face. [NAME] 2 was not wearing a beard cover and was serving food. During an interview on 2/10/26 at 12:15 p.m. with [NAME] 2, [NAME] 2 stated he should have worn a beard cover. During a concurrent observation and interview on 2/10/26 at 12:21 p.m. with Certified Dietary Manager (CDM) in the kitchen, CDM stated it is the expectation for all kitchen staff with beards to wear beard covers. During a review of the facility's P&P titled, DRESS CODE' dated 2023, the P& P indicated, Hair net for hair, if hair is long (over the ears or cover), including beard nets or face covers (if applicable).