STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555918	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fowler Care Center	8448 East Adams Avenue Fowler, CA 93625

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure sufficient supervision to prevent falls for one of six sampled residents (Resident 1), who was assessed as a high fall risk , when Certified Nursing Aide (CNA) 4 left Resident 1 unattended in the restroom while retrieving a diaper and Resident 1 got up from the toilet unassisted, lost his balance and fell. This failure resulted in Resident 1's sustaining a left shoulder fracture.During an interview on 4/2/26 at 2:46 pm with CNA 2, CNA 2 stated CNAs should prepare all necessary supplies before helping residents to the restroom. CNA 2 stated residents must not be left alone in the restroom because they could try to stand up, become unsteady, and fall. CNA 2 stated if additional supplies were needed, CNAs should press the call light button in the restroom and wait for help. During an interview on 4/2/26 at 3:19 pm with CNA 3, CNA 3 stated residents should always be supervised in the restroom to prevent the residents from falling. CNA 3 stated if supplies were needed the CNA should call for help. CNA 2 stated she was taught it was best to stay and supervise the residents. During an interview on 4/2/26 at 3:36 with Licensed Vocational Nurse (LVN), LVN stated it was not safe to leave a resident alone while toileting. LVN stated the CNA would be expected to use the call light to get another staff member to assist with supplies so the residents would not be alone. LVN stated if a resident was left alone in the restroom, they could get up by themselves, fall and get hurt. During a review of the Facility's Declaration Statement dated 3/25/26, the Declaration Statement indicated Resident 1 had loose BM all afternoon and asked CNA 4 to take him to the toilet. CNA 4 wheeled Resident 1 to the restroom and noted Resident 1's diaper was full of stools. CNA 4 decided to grab a diaper that was left on the resident's nightstand. CNA 4 told Resident 1 do not stand up and Resident 1 stated okay, I will unbuckle my shorts till then. When CNA 4 returned, Resident 1 was wobbly on his feet.he hit his left shoulder on the sink. CNA 4 caught Resident 1 and placed him on the toilet. During an interview on 4/2/26 at 3:56 pm with the Minimum Data Set (MDS) nurse, MDS stated the CNA should gather supplies before assisting residents to the restroom. MDS stated if a CNA needed supplies, the CNA should use the emergency call light in the restroom to call for help. MDS stated the CNA should not leave the resident unattended as the resident would be at increased risk for falls/injury. MDS stated Resident 1 had severe cognitive impairment and had difficulty understanding and processing when you speak to him. MDS stated Resident 1 was at high risk for falls, was not good at asking staff for assistance and liked to self-transfer. MDS stated CNA 4 should not have left Resident 1 unattended. During a record review of Resident 1's admission Record (AR), dated 4/10/26, the AR indicated Resident 1 had a history of a broken left arm, type 2 diabetes mellitus (a long-term condition where the body cannot effectively use insulin to manage blood sugar, causing levels to become too high), muscle weakness, broken right shoulder blade, need for assistance with personal care, difficulty walking, alcohol dependence, anemia (lack red blood cells causing people to feel tired, weak, dizzy, or short of breath), conversion disorder with seizures (a condition where a person experiences real, involuntary seizure-like episodes). During a record review of Resident 1's Brief Interview for Mental Status (BIMS; an assessment of a resident's cognitive status; the ability to remember, concentrate, learn new things, (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and/or make decisions that affect their everyday life), dated 3/3/26, the BIMS indicated a score of 3 indicating severe impairment (score of 0 to 7 indicated severe impairment, 8 to 12 indicated moderate impairment, and 13 to 15 indicated minimal to no impairment). During a concurrent interview and record review with the Director of Nursing (DON), Resident 1's Fall Risk Evaluation dated 3/3/26, OT Discharge summary dated [DATE] and Progress Note Type: IDT Notes dated 3/26/25 were reviewed. The Fall Risk Score of 11.0 indicated at High Fall Risk. The OT Discharge Summary indicated Toilet Transfer Partial/Moderate assistance (the patient can perform 50% of the mobility task while the caregiver assists with 50%). The IDT Note indicated .CNA reported that the resident requested assistance to the bathroom for a bowel movement. CNA assisted the resident onto the toilet and instructed the resident in Spanish to remain seated while she briefly left the room to obtain a brief. Upon returning, CNA observed the resident standing and beginning to lose balance. Before full loss of balance occurred, the resident's left shoulder made contact with the sink. During an interview with the DON, the DON stated Resident 1 required supervision and should not have been left alone. The DON stated she would expect the staff to stay with the resident when toileting a high risk for fall resident. The DON stated Resident 1 was alone when he lost his balance. The DON stated the lack of supervision resulted in Resident 1 having a loss of balance and shoulder injury. During a review of the facility's policy and procedure (P&P) titled, Fall Risk Assessment not dated, the P&P indicated .It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control, and provides supervision.to each resident to prevent avoidable accidents. During a review of professional reference review retrieved from https://www.ncbi.nlm.nih.gov/books/NBK43626/table/advances-kline_32.t3/ National Library of Medicine titled, Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 1: Assessment), dated 8/2008 indicated Table 3 Interventions for patients assessed with high risk for falling Standard interventions for high -risk patients.4. Remain with patient while toileting.Additional interventions Physical limitations or motor deficits.3. Supervise and/or assist with toileting. During a review of professional reference review retrieved from https://dudensinglaw.com/nursing-home-obligations-fall-prevention/#:~:text=Toileting%20Plans,Bedrails Dudensing Law titled, Fall Prevention: Nursing Home Obligations, dated 6/30/25 indicated .Unsupervised bathroom use (often due to understaffing) is a common contributor to falls. A scheduled toileting routine tailored to each resident's needs can help minimize the risk of falls.Supervision-Close monitoring is vital for residents at high risk of falling. This can include: .increasing staffing presence during high-risk times or activities.