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	03/07/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51059 Based on observation, interview, and record review, the facility failed to ensure care that promoted rights of the resident and enhancement of quality of life for one of six sampled residents (Resident 147) when resident 147 was not allowed to smoke. This failure resulted in Resident 147 not being able to smoke since admission which led to decreased sense of pleasure and increased anxiety. Findings: During a review of Resident 147's Admission Record (AR- document containing resident personal information), dated 3/6/25, the AR indicated, Resident 147 was admitted to the facility on [DATE], with diagnoses which included psychosis not due to a substance or known physiological condition (a mental health condition characterized by a loss of contact with reality. It is a state of altered perception, cognition, and behavior), major depressive disorder (a common and serious mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life), schizoaffective disorder (a chronic mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder), opioid dependence (physical and psychological reliance on opioids, a substance found in certain prescription pain medications and illegal drugs) and insomnia (a common sleep disorder characterized by difficulty falling asleep, staying asleep, or waking up too early and feeling unrested. It can significantly impact daily life, leading to fatigue, irritability, difficulty concentrating, and reduced productivity). During a review of Resident 147's Minimum Data Set (MDS- a resident assessment tool) assessment, dated 3/5/25, the MDS assessment indicated Resident 147's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) assessment score was 14 out of 15 which indicated Resident 147 had no cognitive deficit (a decline in thinking abilities, like memory, reasoning, and problem-solving). During a review of Resident 147's Progress Note, dated 3/4/25, the Progress Note indicated, .MD [medical doctor] .was in house and spoke to resident and offered her a nicotine patch, but she declined it .MD . recommended for her to not smoke until she recovers from being intubated (a procedure that involves inserting a tube into a patient's airway to help them breathe) at acute [hospital] . (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/4/25 at 2:14 p.m. with Resident 147 in Resident 147's room, Resident 147 was seen sitting in bed rubbing her hands together and frequently repositioning. Resident 147 stated she had not been allowed to smoke since admitted to the facility. Resident 147 stated, I want to be able to smoke it is the only pleasure I have. Resident 147 stated not being allowed to smoke made her feel anxious. Resident 147 stated she was aware of the MD's recommendation to not smoke. Resident 147 stated the Director of Nursing (DON) provided education to her and her mother on the risks of smoking before her throat was healed. Resident 147 stated she had expressed, since admission, to the DON and facility staff she wanted to smoke despite the recommendation not smoke. During an interview on 3/5/25 at 4:50 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 147 was alert and able to make her needs known. CNA 4 stated she was informed by the licensed nurse; Resident 147 could not smoke until her throat was healed. CNA 4 stated Resident 147 had expressed, despite ongoing education, she wanted to smoke. CNA 4 stated she expected all resident rights and preferences to be upheld. CNA 4 stated it was Resident 147's right to smoke against medical advice. During an interview on 3/6/25 at 8:15 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated smoking was a resident right, and all residents should be allowed to smoke if they wanted. LVN 2 stated the role of the nurse was to educate Resident 147 on the risks and benefits of smoking, potential risks to smoking against medical advice and then uphold Resident 147's choice. During an interview on 3/6/25 at 8:21 a.m. with LVN 1, LVN 1 stated she was aware Resident 147 wanted to smoke, since admission, despite medical recommendation not to. LVN 1 stated it was expected all residents received an admission smoking screen by the Social Services Supervisor (SSS) to determine if each resident was a smoker. LVN 1 stated she did not know if Resident 147 had an admission smoking screen completed. During an interview on 3/6/25 at 8:26 a.m. with the SSS, The SSS stated she was responsible to complete an admission smoking screen on all residents. The SSS stated Resident 147 was not identified as a smoker during the admission smoking screen. The SSS stated after completion of Residents 147's admission smoking screen she was made aware Resident 147 was a smoker and wanted to smoke. The SSS stated Resident 147 was advised not to smoke until her throat was healed. The SSS stated Resident 147 had the right to smoke against medical advice if she wanted. During a concurrent interview and record review on 3/6/25 at 8:30 a.m. with the Activities Director (AD), the facility's Resident Smoking Binder, undated, was reviewed. The AD stated the Resident Smoking Binder was up to date and included all residents within the facility who smoked. The AD stated Resident 147's name was not listed in the Resident Smoking Binder. The AD stated it was her responsibility to complete a Resident Safe Smoking Assessment (an assessment to determine if supervision is required for smoking, or if a resident is safe to smoke at all) on every resident who smoked. The AD stated no Resident Safe Smoking Assessment was completed for Resident 147. The AD stated Resident 147 had expressed to her she wanted to smoke. The AD stated Resident 147 was able to make her needs known and had the right to smoke against medical advice. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 8:36 a.m. with the DON, the DON stated Resident 147 was able to make her needs known and was her own responsible party. The DON stated Resident 147 had the right to make her own healthcare choices. The DON stated he expected all resident healthcare choices and requests to be respected and implemented, per facility policy. The DON stated it was Resident 147's right to smoke. The DON stated Resident 147 was not identified as a smoker on her admission smoking screen. The DON stated he expected all resident admission smoking screens to be completed accurately. The DON stated Resident 147's Resident Safe Smoking Assessment had not been completed. The DON stated he expected the Resident Safe Smoking Assessment to be completed once a resident was identified as a smoker, per facility policy. The DON stated Resident 147's medical team recommended Resident 147 not to smoke until her throat was healed. The DON stated Resident 147 received education from the provider, licensed nurses and himself on the risks and benefits of smoking before her throat was healed. The DON stated he was aware Resident 147 wanted to smoke despite the education. The DON stated Resident 147 had the right to smoke against medical advice. The DON stated Resident 147's rights were violated when she was not allowed to smoke for eight days, since admitted . During a review of the facility's job description document titled, Certified Nursing Assistant, dated 2023, the document indicated, .Promotes and protects all residents' rights . During a review of the facility's job description document titled, Charge Nurse, dated 2023, the document indicated, .Performs rounds to ensure resident needs are being met .collaborates with other members of the interdisciplinary team as needed to ensure residents' needs are holistically met .Promotes and protects all resident's rights . During a review of the facility's job description document titled, Social Services Director, dated 2023, the document indicated, .The Social Services Director ensures that staff members are knowledgeable about Resident's Rights and encourages staff to maintain and enhance each resident's dignity in recognition of each resident's individuality. The Director will also advocate for residents and assist them in assertion of their rights within the facility . Promotes and protects all residents' rights . During a review of the facility's job description document titled, Activities Director, dated 2023, the document indicated, .The Activities Director is responsible for directing the development, implementation, supervision and ongoing evaluation of the activities program designed to meet the social, psychosocial and therapeutic needs of the resident . this includes .approaches that are individualized to match the skills, abilities, and interest/preferences of each resident .directing the activity program includes scheduling of activities . monitoring the response, reviewing and evaluating the response to the programs to determine is the activities meet the assessed needs of the resident, and making revisions as necessary . During a review of the facility's policy and procedure (P&P) titled, Activities, dated 11/2024, the P&P indicated, .It is the policy of this facility to provide an ongoing program to support residents in their choices of activities based don their comprehensive assessment, care plan, and preferences .to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being .intended to enhance her/his sense of well-being and to promote or enhance physical cognitive, and emotional health .that promote self-esteem, pleasure, comfort .activities will be designed with the intent to .enhance the resident's sense of well-being .reflect resident's interests .reflect choices of the residents . (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Resident Smoking, dated 11/2024, the P&P indicated, .Resident's who smoke will be further assessed, using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if the resident is safe to smoke at all .The interdisciplinary team, with guidance from the physician, will help to support the resident's right to make an informed decision regarding smoking .Documentation to support decision making will be included in the medical record, including but not limited to: Resident's wishes .Assessment of relevant functional and cognitive factors affecting ability to smoke safely . During a review of the facility's P&P titled, Resident Right's, dated 11/2024, the P&P indicated, .The resident has the right to a dignified existence .and access to .services inside and outside the facility .The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States .The resident has the right to .request, refuse, and/or discontinue treatment .The resident has a right to choose activities .The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident .

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to ensure residents were treated with dignity and respect for five of six sampled residents (Residents' 1, 39, 40, 41, and 97) when: 1. LVN 1 administered medications to Residents' 39, 40, 41 and 97 without closing the privacy curtain or the door. 2. Licensed Vocational Nurse (LVN) 2 checked Resident 1's blood sugar level (BS-amount of sugar in the blood) without closing the privacy curtain or the door. These failures resulted in Residents' 1, 39, 40, 41, and 97 not provided respect and dignity during care which could potentially impact residents' well-being leading to vulnerability, decreased dignity, anxiety, stress and depression. Findings: 1. During a concurrent observation and interview on 3/6/25 at 7:55 a.m. in Station 1 East Hall with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared Resident 40's medications and entered Resident 40's room. Resident 40 was lying in bed and inside the room was another resident. LVN 1 administered Resident 40's medications without closing the privacy curtain or the door. LVN 1 stated she did not close the privacy curtain or the door when she administered Resident 40's medications and should have. LVN 1 stated it was a dignity issue. During a review of Resident 40's AR, dated 3/6/25, the AR indicated Resident 40 was readmitted to the facility on [DATE] with diagnoses which included hypertension, alcoholic cirrhosis (liver is scarred and damaged permanently) and cellulitis (infection of the skin and tissues beneath the skin). During a review of Resident 40's Minimum Data Set (MDS- an assessment tool used to identify resident cognitive[pertaining to reasoning, memory and judgement] and physical functional level), assessment dated [DATE], indicated Resident 40's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 15 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 40 had no cognitive deficit. During a concurrent observation and interview on 3/6/25 at 8:20 a.m. in Station 1 east hall with LVN 1, LVN 1 prepared Resident 39's medications and entered Resident 39's room. Resident 39 was sitting at the edge of the bed playing puzzles and inside the room was another resident. LVN 1 administered Resident 39's medications without closing the privacy curtain or the door. LVN 1 stated she did not close the privacy curtain or the door to give Resident 39 privacy to take her medications and she should have. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 39's Admission Record, dated 3/6/25 the AR indicated Resident 39 was admitted to the facility on [DATE] with diagnoses which included atrial fibrillation (irregular heartbeat), hypertensive heart disease (heart problems caused by prolong high blood pressure) and muscle weakness. During a review of Resident 39's MDS assessment dated [DATE]. Resident 39's BIMS score was 15 out of 15 indicating Resident 39 had no cognitive deficit. During a concurrent observation and interview on 3/6/25 at 8:35 a.m. with LVN 2 in Station two, west hall, LVN prepared Resident 41's medications. Resident 41 was sitting at the edge of the bed and inside the room was another resident. LVN 2 administered Resident 41's medications and did not close the privacy curtain and the door. LVN 2 stated she administered Resident 41's medications and did not close the privacy curtain and the door, and she should have. LVN 2 stated it was Resident 41's resident rights and a dignity issue. During a review of Resident 41's AR dated 3/6/25, the AR indicated Resident 41 was admitted to the facility on [DATE] with diagnoses which included back pain, muscle weakness and hypertension. During a review of Resident 41's MDS assessment dated [DATE], indicated Resident 41's BIMS was 15 out of 15 which indicated Resident 41 had no cognitive deficit. During a concurrent observation and interview on 3/6/25 at 8:42 a.m. with LVN 2 in Station two west wing, LVN 2 prepared Resident 97's medications and entered Resident 97's room. Resident 97 was lying in bed. LVN 2 administered Resident 97's medications and did not close the privacy curtain or door. LVN 2 stated she did not close the privacy curtain and door when she administered Resident 97's medications abd she should have. During a review of Resident 97's AR dated 3/6/25, the AR indicated Resident 97 was admitted to the facility on [DATE] with diagnoses which included kidney failure, hyperlipidemia and dementia (progressive state of decline in mental abilities). During a review of Resident 97's MDS assessment dated [DATE], indicated Resident 97's BIMS assessment score was 10 out of 15 indicating Resident 97 had moderate cognitive deficit. During an interview on 3/7/25 at 10 a.m. with the Director of Staff Development (DSD), the DSD stated the practice was to ensure to provide privacy by closing the privacy curtain and or the door during medication administration including checking of blood sugar level. The DSD stated it was a dignity issue and resident rights to their privacy. During a concurrent observation and interview on 3/6/25 at 7:55 a.m. with LVN 1 in Station 1 west hall, LVN 1 prepared Resident 40's medications. LVN 1 entered Resident 40's room, Resident 40 was lying in bed covered with blanket and answered questions. LVN 1 administered medications to Resident 40 without closing the door or closing the privacy curtain. Residents, staff and visitors walking by and could see Resident 40 taking her medications. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview on 3/6/25 at 11:25 a.m. in east hall cart 2 with LVN 2, LVN 2 entered Resident 1's room. Resident 1 was standing next to his bed located closest to the door and inside the room with Resident 1 was another resident. LVN 2 checked Resident 1's blood sugar without closing the privacy curtain or the door, while the other resident watched LVN 2 performed the blood sugar checked to Resident 1. LVN 2 stated she did not close the privacy curtain or the door when he checked Resident 1's blood sugar and soul have. During a review of Resident 1's Admission Record (AR) dated 3/17/25, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus (high blood sugar level in the blood) and hypertension. During a review of Resident 1's MDS assessment dated [DATE], indicated Resident 1's BIMS assessment did not complete assessment, staff was interviewed for Resident 1's mental status which indicated Resident 1's cognitive skill for daily decision making was modified independence. During an interview on 3/7/25 at 2:15 p.m. with LVN 3, LVN 3 stated it was a facility practice to provide privacy by closing the privacy curtain and doors during medication administration. LVN 3 stated it was the responsibility of the nursing staff to ensure privacy was provided during medication administration. LVN 3 stated there are other residents, staff and visitors walking by and could see residents while taking their medications and fingerstick (a procedure . During an interview on 3/7/25 at 5:55 p.m. with the Director of Nursing (DON), the DON stated his expectation was to ensure privacy was provided to residents during medication administration. The DON stated it was a dignity issue. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 2023, the P&P indicated, . The resident has a right to be treated with respect and dignity . During a review of the facility's policy and procedure (P&P) titled, Promoting/Maintaining Resident Dignity, dated 2024, the P&P indicated, . All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights . Maintain resident privacy . During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 2024, the P&P indicated, . Knock or announce presence . Provide privacy .|

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview, and record review, the facility failed to provide a safe and homelike environment for one of two sampled residents when Resident 12's low air loss machine (designed to distribute patient's body weight over a broad surface area and help skin breakdown) was turned off. This failure had the potential for Resident 12 to develop skin breakdown which could result in pressure ulcer development. Findings: During a concurrent observation and interview on 3/5/25 at 9:40 a.m. in Resident 12's room, Resident 12 was seen lying in bed, covered with blanket and yelling out. Resident 12 did not answer questions asked. Resident 12's bed was positioned in lowest position and had a low air loss mattress. Resident 12's low air loss mattress was turned off and was unplugged from the wall. During a review of Resident 12's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 12 was readmitted to the facility on [DATE] with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk of the same side of the body) and hemiparesis (is a condition characterized by weakness or paralysis) dementia (the loss of thinking, remembering, and reasoning) and muscle weakness. During a review of Resident 12's Minimum Data Set (MDS- an assessment tool used to identify resident cognitive[pertaining to reasoning, memory and judgement] and physical functional level), assessment dated [DATE], indicated Resident 12's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 10 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 12 had moderate cognitive deficit. During a review of Resident 12's Order Summary Report, dated 3/6/25 indicated, . low air loss mattress r/t [related to] limited mobility . During an concurrent observation and interview on 3/5/25 at 9:42 a.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated she was familiar with Resident 12's care. CNA 1 checked the low air loss machine of Resident 12 and stated the low air loss machine was off and it was unplugged. CNA 1 stated, The machine was supposed to be on at all times when a resident has an order to prevent skin breakdown. CNA 1 plugged the machine and turned the machine on. During an interview on 3/5/25 at 9:50 a.m. with Licensed Vocational Nurse (LVN)1, LVN 1 stated she was Resident 12's nurse. LVN 1 stated Resident 12's has an order for low air loss mattress and should have been on at all times to prevent Resident 12 from developing pressure ulcer (localized skin damage that developed as a result of prolonged pressure). LVN 1 stated it was the responsibility of the nursing staff to ensure the low air loss mattress machine was on at all times. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/5/25 at 10:55 a.m. with CNA 2, she stated she was the CNA assigned to Resident 12 and was familiar with his care. CNA 2 stated the low air loss mattress was off in the morning but did not recall if it was unplugged. CNA 2 stated the machine should have been on at all times. During an interview on 3/7/25 at 5:55 p.m. with the Director of Nursing (DON), the DON stated his expectation was for the low air loss machine to be on at all times when resident was in bed to prevent skin breakdown. The DON stated it was the responsibility of the nursing staff to ensure the low air loss machine was on and functioning properly. The DON stated not having the low air machine on put Resident at risk of developing skin ulcer. During a review of the facility's policy and procedure (P&P) titled, Safe and Homelike Environment, dated 2024, the P&P indicated, . In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment . receive care and services safely . and does not pose a safety risk .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive care plan for 10 of 15 sampled residents (Residents 10, 28, 29, 30, 37, 39, 40, 27, 24, and 14) when: 1. Resident's 10, 29, 30, 37, 39, and 40 did not have care plan for enhanced barrier precautions (EBP-infection control strategy, involving use of gowns and gloves during high-contact resident care). These failures placed Residents' 10, 29, 30, 37, 39, and 40 needs not being met. 2. Resident 28 care plan for Enhanced Barrier Precaution (EBP-a set of infection control measures that use personal protective equipment [PPE] to reduce the spread of multidrug-resistant organisms [MDROs]). This failure had the potential for Resident 28's needs being unmet. 3. Resident 27's actives care plan lacked person-centered approach for conversation and socializing. This failure had the potential for missed opportunities for emotional and cognitive stimulation. 4. Resident 24's care plan for impaired cognitive function/dementia was not implemented timely. This failure had the potential for resident 24's needs to not be met and put Resident 24 at an increase for cognitive decline. 5. Resident 14's care plan was not developed to address the use of an anticoagulant (blood thinner) medication. This failure had the potential for Resident 14 to experience severe bruising and bleeding which could lead to serious medical condition and hospitalization . Findings: 1. During a review of Resident 10's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 10 was admitted to the facility on [DATE] with diagnoses which included diabetes (high sugar level in the blood), open wound to right knee, open wound to left knee and muscle weakness. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 10's Minimum Data Set (MDS- an assessment tool used to identify resident cognitive[pertaining to reasoning, memory and judgement] and physical functional level), assessment dated [DATE], indicated Resident 10's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 14 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 10 had no cognitive deficit. During a review of Resident 29's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 29 was admitted to the facility on [DATE] with diagnoses which included dementia (a progressive state of decline in mental abilities) and diabetes. During a review of Resident 29's MDS assessment dated [DATE], indicated Resident 29's BIMS assessment was not able to complete and staff assessment was conducted which indicated Resident 29 had a score of 2 indicating Resident 29 was moderately impaired, decisions poor and required cues and supervision. During a review of Resident 30's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 30 was admitted to the facility on [DATE] with diagnoses which included diabetes, surgical aftercare, and chronic ulcer (wounds that fail to heal within a normal time frame) of left foot. During a review of Resident 30's MDS assessment dated [DATE], indicated Resident 30's BIMS assessment score was 13 out of 15 indicating Resident 30 had no cognitive deficit. During a review of Resident 37's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 30 was admitted to the facility on [DATE] with diagnoses which included open wound, non-pressure chronic ulcer (persistent skin wound that fails to heal properly) of right heel and muscle weakness. During a review of Resident 37's MDS assessment dated [DATE], indicated Resident 37's BIMS assessment score was 15 out of 15 indicating Resident 37 had no cognitive deficit. During a review of Resident 39's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 39 was admitted to the facility on [DATE] with diagnoses which included cellulitis (bacterial skin infection of skin and tissues beneath the skin) of left lower limb, diabetes and muscle weakness. During a review of Resident 39's MDS assessment dated [DATE], indicated Resident 39's BIMS assessment score was 15 out of 15 indicating Resident 39 had no cognitive deficit. During a review of Resident 40's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 28 was admitted to the facility on [DATE] with diagnoses which included cellulitis of unspecified part of limb and pressure ulcer of sacral region. During a review of Resident 40's MDS assessment dated [DATE], indicated Resident 40's BIMS assessment score was 15 out of 15 indicating Resident 40 had no cognitive deficit. (continued on next page)

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	03/07/2025

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/5/25 at 3:50 p.m. with the IP, Resident's 10, 29, 30, 37, 39, and 40's clinical record were reviewed. The IP stated Resident's 10, 29, 30, 37, 39 and 40 did not have care plans for the EBP. The IP stated care plan should have been initiated as soon as Residents' 10, 29, 30, 37, 39 and 40 were placed on EBP. The IP stated care plan directs staff to care for resident needs. The IP stated all licensed nurses were responsible in creating care plan and she was responsible in creating care plan for residents on EBP. During an interview on 3/7/25 at 10:30 a.m. with Director of Staff Development (DSD), the DSD stated care plan are the responsibilities of licensed nurse. The DSD stated licensed nurses are capable of creating care plan. The DSD stated EBP care plan should have been initiated right away when resident was placed on EBP. During an interview on 3/7/25 at 3:45 p.m. with Licensed Vocational Nurse (LVN)1, LVN 1 stated care plan are the responsibility of licensed nurse. LVN 1 stated the IP and DON are responsible in creating EBP care plan to direct staff to care for resident. During an interview on 3/7/25 at 6:15 p.m. with the Director of Nursing (DON), the DON stated the IP was responsible in identifying residents belonging in the EBP and notifying staff of the precautions needed to care for residents. The DON stated care plan should be complete and patient centered. The DON stated IP was responsible in creating care plan and should have initiated care plan right away as soon as resident were determined to be on EBP. During a review of facility's policy and procedure (P&P) titled, Comprehensive Care Plans, dated 2025, the P&P indicated, . 2. The comprehensive care plan will be developed within 7 days . The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished . b. Any services that would otherwise be furnished . 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment . During a review of facility's policy and procedure (P&P) titled, Enhanced Barrier Precaution, dated 2025, the P&P indicated, . All staff receive training on enhanced barrier precautions upon hire and annually .An order for enhanced barrier precaution will be obtained for residents with any of the following: i. Wounds [. chronic wounds such as pressure ulcer . urinary catheters . During a review of facility document titled, Infection Preventionist, Job Description dated 2023, the document indicated, . Establishes facility-wide systems for the prevention, identification, reporting, investigation, and control of infections and communicable diseases . Maintains documentation of infection prevention and control program activities . 51284 2. During observation on 3/4/25 at 10:46 a.m. of resident 28's room, resident 28 was not in facility. Resident 28 had Enhanced Barrier precautions (EBP) sign on the door and a dot next to her name. During record review on 3/4/25 at 4:19 p.m. Resident 28's Admission note dated 5/22/24 stated resident had bilateral nephrostomy tubes (a thin, flexible catheter that drains urine from the kidney into a bag outside the body). (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/5/24 at 10:19 a.m. with Resident 28, in Resident 28's room, Resident 28 was observed lying in bed watching television (TV) in her gown. Resident 28 stated she had her nephrostomy tube removed on 3/4/25. Resident 28 stated that she has a surgical site from the procedure. During a concurrent interview and record review on 3/7/25 at 10:11 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 28's Care Plan dated 3/6/25 indicated EBP was initiated on 3/6/25. LVN 3 Stated this was not an appropriate timeframe. LVN 3 stated that care plans are important to provide specific care to that person. During review of Resident 28's Care Plan, dated 3/6/25, the Care Plan indicated, Resident 28 EBP care plan was created on 3/6/25. During interview on 3/7/25 at 3:11 p.m. with Infection Preventionist (IP), the IP stated EBP is determined by the IP. The IP stated EBP are for wounds, catheters, and EBP are important for residents who are at an increased risk for infection. The IP stated it is her responsibility to obtain an order and created the EBP care plan right away. The IP stated the resident 28 did not have a care plan for EBP prior to survey. During an interview on 3/7/25 at 5:40 p.m. with the Director of Nurses (DON), The DON stated the expectation for care plans to be completed and resident centered. DON stated admission care plan are to be completed within 14 days. During a review of facility's job description document titled, Infection Preventionist, dated 2023, the document indicated, .Oversees resident care activities that increase risk infection .use and care of .catheter, wound care, incontinence care .remains current on new developments related to infection prevention .servers as resource for staff regarding infection prevention During a review of the facilities policy and procedure P&P titled, Enhanced barrier precautions dated 2024, the P&P indicated, . an order for enhanced barrier precautions will be obtained for residents with . Unhealed surgical wounds .and or indwelling medical devices . 3. During a review of Resident 27's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), indicated Resident 27 was admitted to the facility on [DATE] with a diagnoses absence of left below knee, and blindness, both eyes During a concurrent observation and interview on 3/5/25 at 10:34 a.m. with Resident 27, in Resident 27's room, Resident 27 was lying in bed with cell phone in hand. Resident 27 stated she use to go to actives in the dining room until she got sick. Resident 27 stated she liked to talk to people, she liked to order online. Resident 27 stated she liked to listen to the TV with her roommate. (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/6/25 at 2:57 p.m. with the Activities director (AD), Resident 27's Care plan Room visit/ .activity participation record and Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/17/25 the MDS section F -Preferences for Routine and Activities were reviewed. The AD stated she is responsible for progress notes, care plans, and evaluations. The AD stated Resident 27 is a 1:1 room visit, and each visit is 15 minutes long. The AD stated Resident 27 enjoyed localizing in the large dining hall, talking during the room visits and liked to place online orders. The AD stated Resident 27's activity record and care plan were not person centered or individualized. The AD stated it is important Resident 27's activity record and care plan reflect her interests for her mental, emotion and physical health. During an interview on 3/7/25 at 5:40 p.m. with the Director of Nurses (DON), The DON stated the expectation for care plans to be completed and resident centered. DON stated admission care plan are to be completed within 14 days. During a review of the facility's job description document titled, Activities Director, dated 2023, the document indicted, .Contributing to the .care plan .and approaches that are individualized to match the skills, abilities, and interest/preferences of each resident .activities are to be tailored to the resident's unique requirements and skills . During the review of the facilities policy and procedure (P&P) titled, Comprehensive Care Plans, undated, the P&P indicated, . It's the policy of this facility to develop and implement a comprehensive person centered care plan for each resident, consistent with the residents rights, that includes measurable objectives and time frames to meet residents medical, nursing and mental and psychosocial needs and all services that are indicated in the resident's comprehensive assessment and meet professional standards of quality . the comprehensive care plan will include measurable objectives and time frames to meet the residents need as identified in the residence comprehensive assessment . 4. During a Review of Resident 24's Admission Record (AR- document containing residents personal information), dated 3/6/25, the AR indicated, Resident 24 was admitted to the facility on [DATE], with diagnoses Type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), Bipolar Disorder (chronic mental health condition characterized by significant and persistent shifts in mood, energy and activity levels), Unspecified Dementia (a diagnosis used when a person has cognitive decline that cannot be attributed to a specific type of dementia). During a review of Resident 24's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/31/25, the MDS section C indicated, Resident 24 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 6, (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 24 severe cognitive impairment. During an observation on 3/4/25 at 10:05 a.m. Resident 24 was sitting in his wheelchair next to a window with light shinning in. During an interview on 3/5/25 at 12:26 p.m. with Resident 24's Family Member (FM) 1, FM 1 stated Resident 24 needs a lot of care, he gets confused. (continued on next page)

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	03/07/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/7/25 at 10:11 a.m. with LVN 3, Resident 24's Admission Record and Care Plan, dated 3/7/25 were reviewed. LVN 3 stated Resident 24 was admitted with a diagnosis of dementia, and Resident 24 needs to be redirected with his care. LVN 3 stated Resident 24's Impaired cognitive function/dementia Care plan, dated 10/14/24, indicated care plan was created late. LVN 3 stated nurses are responsible to create a care plan. LVN 3 stated care plans are important to know how to care for the resident. During an interview on 3/7/25 at 5:40 p.m. with the DON, the DON stated admission care plans are done by nurses and within 14 days. DON stated a care plan ensures appropriate resident centered care. During a review of the facility's policy and procedure (P&P) titled, Baseline Care Plan, undated, the P&P indicated, .The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective person-centered care of the resident that meet professional standards of quality of care .The admitting nurse, or supervising nurse .shall gather information from the admission physical assessment .and discussion with the resident .A supervising nurse shall verify within 48 hours that a baseline care plan has been developed . During the review of the facilities policy and procedure (P&P) titled, Comprehensive Care Plans, undated, the P&P indicated, . It's the policy of this facility to develop and implement a comprehensive person centered care plan for each resident, consistent with the residents rights, that includes measurable objectives and time frames to meet residents medical, nursing and mental and psychosocial needs and all services that are indicated in the resident's comprehensive assessment and meet professional standards of quality . the comprehensive care plan will include measurable objectives and time frames to meet the residents need as identified in the residence comprehensive assessment . 51059 5. During a review of Resident 14's Admission Record (AR- document containing resident personal information), dated 3/6/25, the AR indicated, Resident 14 was admitted to the facility on [DATE], with diagnoses which included other nondisplaced fracture of sixth cervical vertebra, subsequent encounter for fracture with routine healing (a break in the sixth bone of the neck where fractured pieces of bone have not moved out of alignment and the fractures healing process is progressing normally with routine care), chronic systolic congestive heart failure (a condition where the left ventricle of the heart is weakened, resulting in reduced pumping ability and fluid buildup in the lungs and other parts of the body), chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), unspecified bilateral primary osteoarthritis of hip (a degenerative condition where the cartilage in both hip joints is breaking down, causing pain and stiffness), and muscle weakness generalized. During a review of Resident 14's Minimum Data Set (MDS- a resident assessment tool) assessment, dated 2/19/25, the MDS assessment indicated Resident 14's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) assessment score was 13 out of 15 which indicated Resident 14 had no cognitive deficit (a decline in thinking abilities, like memory, reasoning, and problem-solving). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 14's Order Summary Report, dated 3/6/25, the Order Summary Report indicated, Resident 14 had an active order for .Apixaban Oral Tablet 2.5 [milligrams (MG)- a unit of measurement used to measure the dosage of medication] (Apixaban [a type of medicine known as an anticoagulant. It decreases the clotting ability of the blood and helps prevent harmful blood clots from forming]) .for anticoagulant. The Order Summary Report indicated .order status active .order date 2/13/25 . start date 2/14/25 . During a review of Resident 14's Care Plan, dated 3/6/25, the Care Plan indicated, Resident 14 did not have an anticoagulant care plan. During an interview on 3/6/25 at 8:15 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated anticoagulant medications were expected to be care planned. LVN 2 stated it was expected all care plans were person centered and included current treatments. LVN 2 stated care plans ensured members of the healthcare team provided ongoing monitoring of medication side effects. LVN 2 stated Resident 14 was at risk for uncontrolled bleeding if she was injured and was not monitored. During a concurrent observation and interview on 3/6/25 at 2:31 p.m. with Resident 14 in Resident 14's room, Resident 14 was observed lying in bed. Resident 14 stated she had not received anticoagulant education since admitted to the facility. Resident 14 stated she was not aware of any side effects or complications of anticoagulant medication to monitor for. During a concurrent interview and record review on 3/6/25 at 2:34 p.m. with LVN 1, Resident 14's Order Summary Report (OSR), Medication Administration Record (MAR) and Care Plan, dated 3/6/25 were reviewed. LVN 1 stated Resident 14 had received .Apixaban .2.5 MG .two times a day for anticoagulant . since 2/14/25. LVN 1 stated Apixaban was an anticoagulant. LVN 1 stated anticoagulants were a blood thinner, and Resident 14 could bruise easily and have uncontrolled bleeding if injured. LVN 1 could not locate an anticoagulant care plan for Resident 14. LVN 1 stated a care plan must be in place for all residents to address the use of an anticoagulant. LVN 1 stated it was important the care plan reflected the use of an anticoagulant to ensure education and monitoring interventions were in place. LVN 1 stated the care plan purpose was to reflect each residents' current conditions and alert staff to individualized treatment, side effects, and monitoring precautions. During an interview on 3/6/25 at 2:40 p.m. with the Director of Nursing (DON), the DON stated all care plans were expected to reflect the residents needs and active orders to ensure appropriate monitoring precautions and goals were in place, per facility policy. The DON stated Apixaban was an anticoagulant and all anticoagulants were expected to be care planned. The DON stated it was expected Resident 14 had an anticoagulant care plan to ensure she was being monitored by all members of the healthcare team. The DON stated a care plan ensured continuing education was provided to the resident regarding anticoagulation therapy. The DON stated without an anticoagulant care plan Resident 14 was not being monitored by all members of the healthcare team and was at risk for bruising and uncontrolled internal bleeding. The DON stated it was important all members of the healthcare were aware Resident 14 was on an anticoagulant to accurately reflect her needs, goals, and interventions. The DON stated it was important each resident had a personalized and individualized care plan. During a review of the facility's job description document titled, Charge Nurse, dated 2023, the document indicated, .Initiates, reviews and updates care plans as required . (continued on next page)

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	03/07/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Baseline Care Plan, undated, the P&P indicated, .The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective person-centered care of the resident that meet professional standards of quality of care .The baseline care plan will .include the minimum healthcare information necessary to properly care for a resident including, but not limited to .physician orders . The admitting nurse, or supervising nurse .shall gather information from the admission physical assessment .physician orders, and discussion with the resident . interventions shall be initiated that address the resident's current needs including . any identified needs for supervision .a written summary of the baseline care plan shall be provided to the resident .the summary shall include, at a minimum .a summary of the resident's medications. During a review of the facility's P&P titled, Comprehensive Care Plans, undated, 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 residents rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality .the comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observations, interviews, and record reviews, the facility failed to ensure services provided met professional standards of practice of quality for eight of nine sampled residents (Resident 12, 10, 30, 39, 40, 29, 37 and 28) when: 1. Resident 12 had a physician's order for a low air loss machine (a medical device used primarily to prevent or treat pressure ulcer (bedsores) and was not provided to Resident 12 and was unplugged. This failure resulted for Resident 12 not receiving the necessary care which could lead to development of pressure ulcer. 2. Resident 10, 30, 39, 40, 29, 37, and 38 needed Enhanced Barrier Precaution (EBP- an infection control measures to reduce the risk of transmission of infections) and the Infection Preventionist (IP) did not get a physician's order, did not perform a wound assessment and did not initiate a care plan (a personalized, structured document used to outline the care and treatment the residents needs). This failure placed Resident 10, 30, 39, 40, 29, 37, and 38 at increased risk for widespread transmission of infections which could lead to serious health complications. Findings: 1. During a concurrent observation and interview on 3/5/25 at 9:40 a.m. in Resident 12's room, Resident 12 was seen lying in bed, covered with blanket and yelling out. Resident 12 did not answer questions asked. Resident 12's bed was positioned in lowest position and had a low air loss mattress. Resident 12's low air loss mattress was turned off and was unplugged from the wall. During a review of Resident 12's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 12 was readmitted to the facility on [DATE] with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk of the same side of the body) and hemiparesis (is a condition characterized by weakness or paralysis) dementia (the loss of thinking, remembering, and reasoning) and muscle weakness. During a review of Resident 12's Minimum Data Set (MDS- an assessment tool used to identify resident cognitive[pertaining to reasoning, memory and judgement] and physical functional level), assessment dated [DATE], indicated Resident 12's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 10 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 12 had moderate cognitive deficit. During a review of Resident 12's Order Summary Report, dated 3/6/25 indicated, . low air loss mattress r/t [related to] limited mobility . (continued on next page)

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	555918	A. Building B. Wing	03/07/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/5/25 at 9:42 a.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated she was familiar with Resident 12's care. CNA 1 checked the low air loss machine and found it turned off and unplugged. CNA 1 stated The machine was supposed to be on at all times when a resident has an order to prevent skin breakdown. During an interview on 3/5/25 at 9:50 a.m. with Licensed Vocational Nurse (LVN)1, LVN 1 stated she was Resident 12's nurse. LVN 1 stated Resident 12's had a physician's order for low air loss mattress, and it should have been on at all times to prevent pressure ulcer. LVN 1 stated it was the responsibility of the nursing staff to ensure the low air loss mattress machine was on at all times. During an interview on 3/7/25 at 5:55 p.m. with the Director of Nursing (DON), the DON stated his expectation was for the low air loss machine to be on at all times when resident was in bed to prevent skin breakdown. The DON stated it was the responsibility of the nursing staff to ensure the low air loss machine was on and functioning properly. The DON stated not having the low air machine on put Resident 12 at risk of developing skin ulcer. During a review of the professional reference from https://www.ncbi.nlm.nih.gov/books/NBK333135/ undated, indicated, The Prevention and Management of Pressure Ulcers in Primary and Secondary Care. Pressure redistributing devices. Pressure relieving and redistributing devices are widely accepted methods of trying to prevent the development of pressure ulcers for people considered as being at risk. The devices used include different types of mattresses, overlays, cushions and seating. These devices work by reducing or redistributing pressure, friction or shearing forces . 2. During a review of Resident 10's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 10 was admitted to the facility on [DATE] with diagnoses which included diabetes (high sugar level in the blood), open wound to right knee, open wound to left knee and muscle weakness. During a review of Resident 10's Minimum Data Set (MDS- an assessment tool used to identify resident cognitive[pertaining to reasoning, memory and judgement] and physical functional level), assessment dated [DATE], indicated Resident 10's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 14 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 10 had no cognitive deficit. During a review of Resident 28's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 28 was readmitted to the facility on [DATE] with diagnoses which included retention of urine, hemiplegia and hemiparesis and muscle weakness. During a review of Resident 28's MDS assessment dated [DATE], indicated Resident 28's BIMS assessment score was 15 out of 15 indicating Resident 28 had no cognitive deficit. During a review of Resident 29's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 29 was admitted to the facility on [DATE] with diagnoses which included dementia (a group of symptoms that affects memory, thinking and social abilities) and diabetes [a chronic medical condition that affects how the body process sugar]. (continued on next page)

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	555918	A. Building B. Wing	03/07/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 29's MDS assessment dated [DATE], indicated Resident 29's BIMS assessment was not able to complete and staff assessment was conducted which indicated Resident 29 had a score of 2 indicating Resident 29 was moderately impaired, decisions poor and required cues and supervision. During a review of Resident 30's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 30 was admitted to the facility on [DATE] with diagnoses which included diabetes, surgical aftercare, and chronic ulcer of left foot. During a review of Resident 30's MDS assessment dated [DATE], indicated Resident 30's BIMS assessment score was 13 out of 15 indicating Resident 30 had no cognitive deficit. During a review of Resident 37's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 30 was admitted to the facility on [DATE] with diagnoses which included open wound, non-pressure chronic ulcer of right heel and muscle weakness. During a review of Resident 37's MDS assessment dated [DATE], indicated Resident 37's BIMS assessment score was 15 out of 15 indicating Resident 37 had no cognitive deficit. During a review of Resident 39's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 39 was admitted to the facility on [DATE] with diagnoses which included cellulitis of left lower limb, diabetes and muscle weakness. During a review of Resident 39's MDS assessment dated [DATE], indicated Resident 39's BIMS assessment score was 15 out of 15 indicating Resident 39 had no cognitive deficit. During a review of Resident 40's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 28 was admitted to the facility on [DATE] with diagnoses which included cellulitis of unspecified part of limb and pressure ulcer of sacral region. During a review of Resident 40's MDS assessment dated [DATE], indicated Resident 40's BIMS assessment score was 15 out of 15 indicating Resident 40 had no cognitive deficit. During a concurrent interview and record review on 3/5/25 at 3:23 p.m. with IP, IP stated she had been the IP in the facility for over a year. The IP stated her role includes monitoring infection control and antibiotic use. The IP stated there are seven residents on EBP. The IP stated all seven residents on EBP did not have physician's orders. The IP stated according to facility policy and procedure, she should have placed the physician's order on the day Residents' 10, 30, 39, 40, 29, 37 and 28 were placed on EBP. The IP stated Residents' 10, 30, 39, 40, 29, 37 and 28 did not have EBP care plans and should have. The IP stated care plans should be started within 24 hours. The IP stated she did not complete assessment or documentation for the residents' wounds. The IP stated as a result she did not know whether resident wounds were improving or getting worse because there was documentation. (continued on next page)

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	03/07/2025

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/7/25 at 6:05 p.m. with the Director of Nursing (DON), the DON stated the IP was responsible in identifying residents belonging in the EBP and notifying staff of the precautions needed to care for residents. The DON stated physician order was needed as soon as a resident was placed on EBP. The DON stated the IP should have called Medical Doctor (MD) and get the order. The DON stated his expectation was for the IP to do her job. During a review of facility document titled, Infection Preventionist, Job Description dated 2023, the document indicated, . Establishes facility-wide systems for the prevention, identification, reporting, investigation, and control of infections and communicable diseases . Maintains documentation of infection prevention and control program activities . During a review of the professional reference from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html undated, indicated, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Implementation of Enhanced Barrier Precautions . 19. If a nursing home is receiving a resident known to be colonized with a MDRO from an acute care hospital, do they need to continue Contact Precautions in the facility, or can Enhanced Barrier Precautions be used? The resident should be maintained on Contact Precautions in the nursing home if he or she has acute diarrhea, draining wounds, or other sites of secretions or excretions that are unable to be covered or contained or for a limited period of time during a suspected or confirmed MDRO outbreak investigation. If none of these are present, Enhanced Barrier Precautions would typically be appropriate for the management of this resident, unless otherwise directed by public health authorities . 23. The guidance describes that all residents with wounds would meet the criteria for Enhanced Barrier Precautions. What is the definition of a wound in relation to this guidance? In the guidance, wound care is included as a high-contact resident care activity and is generally defined as the care of any skin opening requiring a dressing. However, the intent of Enhanced Barrier Precautions is to focus on residents with a higher risk of acquiring an MDRO over a prolonged period of time. This generally includes residents with chronic wounds, and not those with only shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers [are open sores that typically develop on the feet of individuals with diabetes [a chronic medical condition that affects how the body process sugar], and chronic venous stasis ulcers [wound develops on the lower leg as a result of poor blood circulation]. Ostomies [a surgical opening in the body to allow waste to exit], such as colostomies or ileostomies, are not defined as a wound for Enhanced Barrier Precautions .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP) have the specific competencies, and skill sets necessary to ensure residents who required Enhanced Barrier Precaution (EBP) were properly managed to prevent the risk for infections for seven of seven sampled residents (Residents' 10, 30, 39, 40, 29, 37 and 28) when the IP demonstrated a breakdown in following critical infection control policies and procedures. These failures placed Residents' 10, 30, 39, 40, 29, 37 and 28 at increased risk for infection. Findings: During a review of Resident 10's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 10 was admitted to the facility on [DATE] with diagnoses which included diabetes (high sugar level in the blood), open wound to right knee, open wound to left knee and muscle weakness. During a review of Resident 10's Minimum Data Set (MDS- an assessment tool used to identify resident cognitive[pertaining to reasoning, memory and judgement] and physical functional level), assessment dated [DATE], indicated Resident 10's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 14 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 10 had no cognitive deficit. During a review of Resident 28's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 28 was readmitted to the facility on [DATE] with diagnoses which included retention of urine, hemiplegia and hemiparesis and muscle weakness. During a review of Resident 28's MDS assessment dated [DATE], indicated Resident 28's BIMS assessment score was 15 out of 15 indicating Resident 28 had no cognitive deficit. During a review of Resident 29's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 29 was admitted to the facility on [DATE] with diagnoses which included dementia () and diabetes During a review of Resident 29's MDS assessment dated [DATE], indicated Resident 29's BIMS assessment was not able to complete and staff assessment was conducted which indicated Resident 29 had a score of 2 indicating Resident 29 was moderately impaired, decisions poor and required cues and supervision. During a review of Resident 30's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 30 was admitted to the facility on [DATE] with diagnoses which included diabetes, surgical aftercare, and chronic ulcer of left foot. During a review of Resident 30's MDS assessment dated [DATE], indicated Resident 30's BIMS assessment score was 13 out of 15 indicating Resident 30 had no cognitive deficit. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 37's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 30 was admitted to the facility on [DATE] with diagnoses which included open wound, non-pressure chronic ulcer of right heel and muscle weakness. During a review of Resident 37's MDS assessment dated [DATE], indicated Resident 37's BIMS assessment score was 15 out of 15 indicating Resident 37 had no cognitive deficit. During a review of Resident 39's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 39 was admitted to the facility on [DATE] with diagnoses which included cellulitis of left lower limb, diabetes and muscle weakness. During a review of Resident 39's MDS assessment dated [DATE], indicated Resident 39's BIMS assessment score was 15 out of 15 indicating Resident 39 had no cognitive deficit. During a review of Resident 40's Admission Record, (AR) dated 3/6/25, the AR indicated Resident 28 was admitted to the facility on [DATE] with diagnoses which included cellulitis of unspecified part of limb and pressure ulcer of sacral region. During a review of Resident 40's MDS assessment dated [DATE], indicated Resident 40's BIMS assessment score was 15 out of 15 indicating Resident 40 had no cognitive deficit. During a concurrent interview and record review on 3/5/25 at 3:23 p.m. with IP, IP stated she had been the IP in the facility for over a year. The IP stated her role includes monitoring infection control and antibiotic use. The IP stated there are seven residents on EBP. The IP stated all seven residents on EBP did not have physician's orders. The IP stated according to facility policy and procedure, she should have placed the order on the day Residents' 10, 30, 39, 40, 29, 37 and 28 were placed on EBP. The IP stated Residents' 10, 30, 39, 40, 29, 37 and 28 did not have EBP care plans and should have. The IP stated care plans should be started within 24 hours. The IP stated she did not complete assessment or documentation for the residents' wounds. The IP stated as a result she did not know whether resident wounds were improving or getting worse because there was no documentation. During an interview on 3/7/25 at 6:05 p.m. with the Director of Nursing (DON), the DON stated the IP was responsible in identifying residents belonging in the EBP and notifying staff of the precautions needed to care for residents. The DON stated physician order was needed as soon as a resident was placed on EBP. The DON stated the IP should have called Medical Doctor (MD) and get the order. The DON stated his expectation was for the IP to do her job. During a review of facility document titled, Infection Preventionist, Job Description dated 2023, the document indicated, . Establishes facility-wide systems for the prevention, identification, reporting, investigation, and control of infections and communicable diseases . Maintains documentation of infection prevention and control program activities .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to ensure the facility medication error rate did not exceed five percent. The facility's medication error was 6.9%. 1. Licensed Vocational Nurse (LVN) 1 did not follow medication direction when she administered lactulose solution (medication used to treat constipation) to Resident 40. This failure resulted for Resident 40 not receiving the full therapeutic benefit of the prescribed lactulose solution (medication used to treat constipation) which could lead to constipation or serious health condition. 2. LVN 1 administered metformin (medication used to treat diabetes) medication without food and did not follow the physician's order to administer with food. This failure had the potential risk for Resident 39 to experienced gastrointestinal upset (GI-gastric upset like diarrhea) and could decrease the absorption of Metformin leading to less effective blood sugar control. Findings: 1. During a concurrent medication administration pass observation and interview on 3/6/25 at 8:05 a.m. at the east hall, LVN 1 was preparing Resident 40's medications and poured lactulose solution in a clear medication cup. LVN 1 administered Resident 40's medications. LVN 1 stated she did not administer 30 ml (milliliter-unit of measurement) of lactulose as ordered. LVN 1 stated she should have administered 30 ml. as ordered but instead administered 20 ml to Resident 40. LVN 1 stated Resident 40 did not received the whole medication dose as ordered by MD which could lead to constipation. During a review of Resident 40's Admission Record, dated 3/6/25, the admission record indicated Resident 40 was readmitted to the facility on [DATE] with diagnoses which included alcoholic cirrhosis of liver (permanent scarring of the liver), duodenal ulcer (sore that developed in the lining of the first part of the small intestine) and unsteadiness on feet. During a review of Resident 40's Order Summary Report, (OSR) dated 3/6/25, the OSR indicated, . Lactulose Oral Solution 10GM [gram- unit of measurement]/15ML [milliliter-unit of measurement] (Lactulose) Give 30ml by mouth three times a day . During an interview on 3/7/25 at 9:18 a.m. with LVN 2, LVN 2 stated it was important to follow medication order when administering medications to residents. LVN 2 stated administering medication less than the ordered amount was under dosing and does not help resident. During an interview on 3/7/25 at 10:25 a.m. with the Director of Staff Development (DSD), the DSD stated it was important to follow medication order and give the correct amount of medication as ordered by medical doctor (MD) to be effective. The DSD stated the practice was to administer the correct amount of medication as ordered to be effective. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/7/25 at 5:55 p.m. with the Director of Nursing (DON), The DON stated licensed nurse should have followed the medication order and measured the correct amount of lactulose for Resident 40. The DON stated failing to administer the correct dosage could result in the medication not reaching the required potency. 2. During a concurrent medication administration pass observation and interview on 3/6/25 at 8:15 a.m. at east wing medication cart 1, LVN 1 prepared Resident 39's medications. LVN 1 administered Resident 39's medications without food. LVN 1 stated the medication direction was to administer metformin with food. LVN 1 stated she did not give food to Resident 39 when she administered the metformin. LVN stated the metformin given on an empty stomach could cause GI distress. During a review of resident 39's Admission Record, dated 3/6/25, the admission record indicated Resident 39 was admitted to the facility on [DATE] with diagnoses which included diabetes (high blood sugar level in the blood), anemia (body does not have enough healthy red blood cells) and muscle weakness. During a review of Resident 39's Order Summary Report, (OSR) dated 3/6/25, the OSR indicated, . metformin HCl [brand name] [hydrochloride] Oral 500MG [milligram-unit of measurement] Give one [1] tablet by mouth two times a day for Give with meals . During an interview on 3/7/25 at 2:05 p.m. with LVN 3, LVN 3 stated the practice was to always follow the medication order and directions when administering medications. LVN 3 stated if the medication order includes a direction to give with food, it should be followed. LVN 3 stated medications requiring food should be given while the resident was eating, or a snack should be provided if resident was not eating to prevent GI discomfort. During an interview on 3/7/25 at 5:55 p.m. with the Director of Nursing (DON), the DON stated his expectation was for the licensed nurse to administer metformin while resident was eating. The DON stated licensed nurse could have offered a snack with the metformin after Resident 39 finished eating to avoid gastrointestinal upset and ensure proper medication absorption. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 11/24, the P&P indicated, .Ensure the that the six rights of medication administration are followed: . Right dose . Administer medication as ordered . Provide appropriate amount of food and fluid . During a review of the facility's policy and procedure (P&P) titled, Medication Error, dated 11/24, the P&P indicated, . Medication administered not in accordance with the prescriber's order . Incorrect dose, route of administration, dosage form . Administering medications without adequate fluids, without food or antacids .

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51059 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 27) were provided special eating equipment when Resident 27's lunch was not served on an adaptive equipment scoop plate per her meal ticket. This failure resulted in Resident 27's individualized care needs not met which led to difficulty eating, delayed in finishing her meals and the potential risk for decreased oral intake. Findings: During a review of Resident 27's Admission Record (AR- document containing resident personal information), dated 3/6/25, the AR indicated, Resident 27 was admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (complete and partial weakness on the left side of the body following a stroke [blood flow to the brain is decreased, causing brain cells to die]) , chronic obstructive pulmonary disease (COPD-air flow obstruction and inflammation of the airways, leading to difficulty breathing) with acute exacerbation (sudden worsening of COPD symptoms, such as increased breathlessness, cough, and/or sputum production, that requires additional treatment and can worsen health status), type 2 diabetes mellitus with other diabetic ophthalmic complication (high levels of sugar in the blood that have caused vision problems) , muscle weakness and chronic kidney disease (a long-term condition where the kidneys gradually lose their ability to filter waste products and excess fluid from the blood). During a review of Resident 27's Minimum Data Set (MDS- a resident assessment tool) assessment, dated 1/18/25, the MDS assessment indicated Resident 27's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) assessment score was 15 out of 15 which indicated Resident 27 had no cognitive deficit (a decline in thinking abilities, like memory, reasoning, and problem-solving). The MDS assessment indicated Resident 27's functional abilities (the capacity to perform daily tasks and activities) had impairments on both sides of her upper extremities. During a concurrent observation and interview on 3/4/25 at 11:55 a.m. with the Certified Dietary Manager (CDM) in the kitchen during tray line (where meals are prepared, organized, and distributed o patients), Resident 27's lunch was seen on a regular plate. Resident 27's meal ticket stated, Adaptive Equipment: Scoop Plate. The CDM stated Resident 27's lunch was on a regular plate. The CDM stated per Resident 27's meal ticket she required a scoop plate. The CDM stated the cook and dietary aide were responsible to plate meals per the meal ticket. The CDM stated occupational therapy (OT) determined Resident 27's need for an adaptive scoop plate and she placed the order on the meal ticket. The CDM stated all adaptive eating equipment devices were listed on the meal ticket. The CDM stated a scoop plate had high plate edges to assist Resident 27 to scoop food on to her utensil. The CDM stated the facility did not have a scoop plate. The CDM stated the facility had one scoop plate and it broke the previous day. The CDM stated a new scoop plate had been ordered and would arrive in one day. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/4/25 at 12:31 p.m. with Resident 27 in Resident 27's room, Resident 27 was seen eating lunch with her fingers on a regular plate. Resident 27 stated she typically used a special plate that helped her eat. During an interview on 3/5/25 at 12:02 p.m. with the Director of Staff Development (DSD), the DSD stated kitchen staff were responsible to accurately plate each meal per the meal ticket. The DSD stated Licensed Vocational Nurses (LVN) were responsible to ensure each meal ticket matched the plated dish before it was served to the resident. The DSD stated LVN's checked meal trays before serving to residents to ensure the correct diet, texture and adaptive equipment device were present. During an interview on 3/5/25 at 2:36 p.m. with the Registered Dietician (RD), the RD stated she expected all meal ticket orders to be followed. The RD stated the scoop plate made it easier for Resident 27 to eat. The RD stated Resident 27 was at risk for decreased oral intake if she could not easily eat her meal. During an interview on 3/6/25 at 8:15 a.m. with LVN 2, LVN 2 stated adaptive eating equipment devices were listed on the meal ticket. LVN 2 stated the scoop plate was an adaptive eating equipment device. LVN 2 stated all meals were expected to be served per the meal ticket order. LVN 2 stated the scoop plate helped Resident 27 eat with limited assistance and made it easier to scoop food onto utensils using the raised plate edges. LVN 2 stated Resident 27 was at risk for decreased oral intake or frustration if she could not easily eat her meal. LVN 2 stated LVN's were responsible to ensure meal ticket orders were followed before serving every meal. During an interview on 3/6/25 at 8:53 a.m. with the Administrator (ADM), the ADM stated she expected kitchen staff to plate meals accurately per the meal ticket order. The ADM stated the scoop plate was an adaptive equipment device used for eating. The ADM stated Resident 147's meal should have been plated per the meal ticket order. During an interview on 3/6/25 at 10:14 a.m. with Resident 27, Resident 27 stated it took longer to eat her meal with no scoop plate. Resident 27 stated she preferred the scoop plate because it was easier to eat on. During an interview on 3/6/25 at 11:35 a.m. with Certified Nursing Assistant (CNA) 7, CNA 7 stated Resident 27 used a scoop plate to eat. CNA 7 stated the scoop plate had raised, curved edges that made it easier for Resident 27 to scoop food onto a utensil. CNA 7 stated Resident 27 had limited mobility in her upper extremities and the scoop plate helped her eat with limited assistance. CNA 7 stated Resident 27 was at risk for decreased oral intake, frustration and decreased independence without the scoop plate. During an interview on 3/7/25 at 5:34 p.m. with the Director of Nursing (DON), the DON stated he expected all meal ticket orders to be followed. The DON stated the scoop plate was an adaptive equipment device. The DON stated he expected all kitchen staff to plate meals per the meal ticket order. The DON stated he expected all LVN's to ensure meal ticket orders matched the plated meal before serving to each resident. The DON stated he expected CNA's to identify any plated meal errors when assisting with meal set up. The DON stated Resident 27's meal should have been plated per the meal ticket order on a scoop plate. The DON stated Resident 27 was at risk for decreased oral intake and weight loss if she could not eat her meal. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's job description document titled, Dietary Cook, dated 2023, the document indicated, .ensures appropriate utensils and equipment are provided with the resident's meal tray . During a review of the facility's job description document titled, Dietary Aide, dated 2023, the document indicated, .sets up meal trays, food carts, dining room, etc., as instructed .assists in checking dietary trays before distribution and delivering food carts to designated areas . During a review of the facility's job description document titled, Dietary Manager, dated 2023, the document indicated, .overseeing safe and timely meal preparation, including the provision of meals and/or supplements in accordance with resident's needs, preferences, and care plan .uses forecasts .inventory, and equipment records to plan the purchase of food, supplies, and equipment .processes new diet orders and diet changes. Keeps diet cards updated . During a review of the facility's job description document titled, Certified Nursing Assistant, dated 2023, the document indicated, .coordinates dining room services at assigned mealtimes, including set-up and clean-up, meal tray delivery, feeding assistance, and documentation of meal intake . During a review of the facility's policy and procedure (P&P) titled, Food Safety Requirements, dated 11/2022, the P&P indicated, .Food will also be .distributed and served in accordance with professional standards for food service safety . During a review of the facility's P&P titled, Adaptive Feeding Equipment, dated 11/2024, the P&P indicated, . The dietary department should be notified of resident's needing adaptive feeding equipment; the equipment is stored and maintained in the dietary department. Appropriate utensils should be placed on the resident's food tray, at each meal, and returned to the dietary department, on the food tray, for sanitization .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51059 Based on observation, interview, and record review, the facility failed to ensure food and ice were stored, prepared, and served safely in accordance with professional standards for food service safety for 44 out of 44 residents at the facility when: 1. Honey mustard packets ready for residents' use were expired. 2. Honey mustard packets and frozen sausage pizza toppings were not labeled. 3. A dietary aides personal belonging was observed on the kitchen spice preparation rack. 4. The ice machine water pump (a compartment within the ice machine that carries water) was observed with black spots. These failure resulted to unsafe food handling practices which had the potential risk to caused cross contamination (occurs when harmful bacteria are transferred from one surface or food to anther) and foodborne illness (occurs when a person consume contaminated food or beverages) for the 44 residents at the facility. Findings: 1. During a concurrent observation and interview on [DATE] at 9:32 a.m. with the Certified Dietary Manager (CDM) in the kitchen dry storage room, a brown box filled with individual honey mustard packets was observed to have a use by date (is the last date recommended for the consumption of a product while its at its best quality) of [DATE]. The CDM stated the individual honey mustard packets were expired per the use by date of [DATE] on the brown box. The CDM stated it was the responsibility of the entire kitchen staff to identify expired food items in the kitchen. The CDM stated all expired food items were expected to be removed from the kitchen. The CDM stated she completed kitchen rounds twice a week. The CDM stated the individual honey mustard packets should have been identified during kitchen rounds and removed. (continued on next page)

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	03/07/2025

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During a concurrent observation and interview on [DATE] at 9:32 a.m. with the CDM in the kitchen dry storage room, a brown box filled with individual honey mustard packets was observed to have no open date (refers to the date a product was opened or first used). The CDM could not locate an open date on the box. During an observation with the CDM in the kitchen freezer, frozen sausage pizza topping was observed with no receive date, open date, or use by date. The CDM could not determine the received date, open date, or use by date on the frozen sausage pizza topping. The CDM stated all food items were expected to have a label with the receive date, open date, and use by date. The CDM stated it was the responsibility of the entire kitchen staff to label food items with the receive date, open date, and use by date. The CDM stated it was the responsibility of the entire kitchen staff to identify food items that were not labeled correctly. The CDM stated she completed kitchen rounds twice a week and reviewed food items for accurate labeling. The CDM stated food items were labeled with receive date, open date, and use by dates to prevent the use of expired food items when cooking or serving food to residents. The CDM stated residents were at risk for foodborne illness is they ate expired honey mustard packets or frozen sausage pizza topping. During an interview on [DATE] at 2:36 p.m. with the Registered Dietician (RD), the RD stated she completed monthly kitchen rounds to ensure food items were stored, prepared, distributed and served in accordance with professional standards for food safety. The RD stated the most recent kitchen audit was approximately two weeks ago but could not state the exact date. The RD stated she used the Department of Health and Human Services Centers for Medicare and Medicaid Services, Kitchen/Food Service Observation form to complete monthly kitchen rounds. The RD stated she did not identify the individual honey mustard packets or frozen sausage pizza toppings during her last monthly kitchen round. The RD stated all expired items were expected to be removed during monthly rounds. The RD stated all food items were reviewed during monthly kitchen rounds to ensure all food items were labeled with receive date, open date, and use by dates. The RD stated she expected all staff to remove expired food items when expired and label all food items with a receive date, open date, and use by date, per facility policy and professional standards. The RD stated residents were at risk for foodborne illness if they ate spoiled honey mustard packets or frozen sausage pizza toppings. During an interview on [DATE] at 8:48 a.m. with the CDM, the CDM stated when hired all kitchen staff were trained to label and date food items with the receive date, open date, and use by date. The CDM stated when hired all kitchen staff were trained to discard expired food items. The CDM stated on [DATE] she provided an in-service to all kitchen staff for labeling food items with receive date, open date, and use by dates. During an interview on [DATE] at 8:53 a.m. with the Administrator (ADM), the ADM stated she oversaw the CDM and RD. The ADM stated she did not complete any observations with the CDM and RD during kitchen rounds. The ADM stated the CDM and RD used the Department of Health and Human Services Centers For Medicare and Medicaid Services, Kitchen/Food Service Observation form to complete monthly kitchen rounds together. The ADM stated the most recent kitchen audit completed by the CDM and RD was approximately two weeks ago but could not state the exact date. The ADM stated she was responsible to review the kitchen audit form after it was completed. The ADM stated she expected all kitchen staff to remove expired food items, per facility policy and training. The ADM stated she expected all kitchen staff to label and date food items with the receive date, open date, and use by date, per facility policy and training. (continued on next page)

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	555918	A. Building B. Wing	03/07/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's most recent kitchen audit form titled, Department of Health and Human Services Centers For Medicare and Medicaid Services, Kitchen/Food Service Observation, undated, the form indicated the entire kitchen was assessed. The form indicated, a check mark was placed next to the observation, .Food products are discarded on or before the expiration date .food stored, prepared, distributed, and served in accordance with professional standards for food safety . indicating food storage was reviewed and assessed for expired food items. 3. During a concurrent observation and interview on [DATE] at 9:32 a.m. with the CDM and Dietary Aide (DA) 1 in the kitchen, a cell phone was observed on the kitchen spice preparation rack. The CDM and DA 1 verified the cell phone on the kitchen spice preparation rack. DA 1 stated the cell phone was hers and should not be placed on the kitchen spice preparation rack. The CDM stated no personal belongings were allowed in the kitchen. The CDM stated all personal belongings were expected to be kept in employee lockers or on the designated rack outside of the kitchen. The CDM stated personal items in the kitchen presented an infection control issue and could cause food borne illness. During an interview on [DATE] at 2:36 p.m. with the RD, the RD stated she expected all kitchen staff to maintain a safe, clean and sanitary kitchen environment. The RD stated she expected all staff to follow facility infection control policies. The RD stated a cell phone on the kitchen spice preparation rack did not maintain a safe, clean and sanitary kitchen environment or follow facility infection control policies. The RD stated it was a risk for cross contamination and food borne illness to have a cell phone on the kitchen spice preparation rack. During an interview on [DATE] at 8:48 a.m. with the CDM, the CDM stated when hired all kitchen staff were trained to keep personal items out of the kitchen. The CDM stated she expected all kitchen staff to follow orientation training. The CDM stated on [DATE] she provided an in-service to all kitchen staff regarding cell phone storage outside the kitchen and allowed only on breaks. During an interview on [DATE] at 8:53 a.m. with the ADM, the ADM stated she expected all kitchen staff to keep personal belongings out of the kitchen. The ADM stated no personal belongings should be placed on the kitchen spice preparation rack. The ADM stated it was unsanitary to have a cell phone on the kitchen spice preparation rack and could contaminate food and lead to food borne illness. During an interview on [DATE] at 5:34 p.m. with the Director of Nursing (DON), the DON stated he expected all kitchen staff to follow facility policies which included, infection control, hygiene and food safety. The DON stated he expected all kitchen staff to follow infection control, hygiene and food safety trainings and in-services. The DON stated he expected all food items to be labeled with a receive date, open date and use by date to ensure no food items were served expired. The DON stated all residents who ate at the facility were at risk for receiving an expired food item if left in the kitchen. The DON stated expired food items could cause gastrointestinal (stomach) upset or foodborne illness and make residents sick. 4. During a concurrent observation and interview on [DATE] at 2:24 p.m. with the CDM and Maintenance Supervisor (MS) in the employee breakroom, black dots substance was seen on the water pump in the ice machine. The CDM and MS verified the black dots on the water pump in the ice machine. The MS removed the black dots substance on the water pump with a white napkin. The CDM and MS verified the black substance on the white napkin. The CDM stated she expected the ice machine to be clean, sanitary and free from black substance. (continued on next page)

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	555918	A. Building B. Wing	03/07/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on [DATE] at 2:36 p.m. with the RD, a picture of the ice machine, dated [DATE], was reviewed. The RD stated she observed black substance as black dots on the water pump. The RD stated she expected the ice machine to be free from black substance. The RD stated the black substance on the water pump contaminated the ice and was a risk for foodborne illness to all 44 residents who ate at the facility. During an interview on [DATE] at 8:53 a.m. with the ADM, the ADM stated she expected the ice machine to always be free from black substance and clean. During a concurrent observation and interview on [DATE] at 5:34 p.m. with the DON, a picture of the ice machine, dated [DATE], was reviewed. The DON stated he observed black substance as black dots on the water pump. The DON stated he expected the ice machine to be clean and free from black substance. During a review of the facility's job description document titled, Dietary Aide, dated 2023, the document indicated, . follows appropriate safety and hygiene measures at all times to protect residents .follows established infection control policies and procedures .as a condition of employment, completes all assigned training and skills competency .maintains food storage areas in a clean and properly arranged manner at all times .assists in inventory and storing in-coming food, supplies, etc., as necessary . During a review of the facility's job description document titled, Dietary Manager, dated 2023, the document indicated, .oversees the budget and purchasing of food and supplies, and food preparation, services, and storage .maintains a clean and sanitary environment .prepares cleaning schedules and maintain equipment to ensure food safety .ensures proper sanitation and safety practices of staff .establishes a culture of compliance by adhering to all facility policies and procedures .follows appropriate safety and hygiene measures at all times to protect residents .follows established infection control policies and procedures . During a review of the facility's job description document titled, Dietician, dated 2023, the document indicated, .performs regular inspections of food service areas for sanitation, order, safety, and proper performance of assigned duties .follows established infection control policies and procedures . During a review of the facility's job description document titled, Maintenance Director, dated 2023, the document indicated, .follows appropriate safety and hygiene measures at all times to protect residents . follows established infection control policies and procedures . During a review of the facility's job description document titled, Administrator, dated 2023, the document indicated, . conducts periodic observations of in-service education to ensure staff members delivering the education are competent with the knowledge and skill set required to accomplish employee learning . During a review of the facility's competency checklist document titled, Dietary Manager Competency, dated [DATE], the document indicated, the CDM received initial training on, .infection control .food storage .meal preparation .tray line/diet card . and demonstrated competency. (continued on next page)

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	555918	A. Building B. Wing	03/07/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's competency checklist document titled, Food & Nutrition: Competency Checklist-Food Service Worker, dated [DATE], the document indicated, DA 1 received initial training on, . infection control practices . sources of food borne illness .correctly label and date foods . and demonstrated competency. During a review of the facility's in-service record document titled, Label/date, Puree Technique, [NAME] Temp vs Holding Temp, Temp Danger Zone, dated [DATE], the document indicated, the document indicated, .All foods must have a label w/ [with] what it is .R: receive date .O: open date .UB: use by date . During a review of the facility's in-service record document titled, Cell Phones, Ear Pods, Breaks, Rest of the time is company time, need to clean or organize or re-stock, dated [DATE], the document indicated, cell phones were only allowed on breaks. During a review of the facility's policy and procedure (P&P) titled, Store/Prepare/Serve Guidelines, dated , d+[DATE], the P&P indicated, .Food should be provided in a form .that meets each resident's individual needs in accordance with his or her assessment and care plan . During a review of the facility's P&P titled, Food Safety Requirements, dated ,d+[DATE], the P&P indicated, . Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety . food safety practices shall be followed throughout the facility's entire food handling process . storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms .equipment used in the handling of food .and other equipment that comes in contact with food .staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects .additional strategies to prevent foodborne illness include .cleaning and sanitizing the internal competent of the ice machine . During a review of the facility's P&P titled, Ice Machines and Portable Ice Carts, dated ,d+[DATE], the P&P indicated, .it is the policy of this facility to ensure that ice machines/carts are .cleaned, and maintained as per Federal, State, and local, or facility guidance .and current standards of practice . ice machines/carts can be prone to microbial contamination due to .poor cleaning or maintenance of equipment .proper cleaning, maintenance, and infection control in relation to ice machines is important to decrease the risk of illness to residents, staff and visitors .The maintenance director or other designee is responsible for cleaning and maintain the ice machine at the facility . The ice machine(s) or carts will be cleaned at any time contamination may have occurred or when visibly soiled . During a review of the facility's P&P titled, Infection Prevention and Control Program, dated ,d+[DATE], the P&P indicated, .this facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary and comfortable environment .all staff are responsible for following all policies and procedures related to the program .standard precautions .environmental cleaning and disinfection shall be performed according to facility policy .all staff have responsibilities related to the cleanliness of the facility .

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	03/07/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation and interview, the facility failed to implement and maintain an effective infection prevention and control program to prevent the transmission of infection for 11 out of 11 sampled residents (Residents' 8, 9, 23, 24, 26, 33, 35, 39, 41, 44, and 97) when nursing staff did not provide or assist residents in performing hand hygiene before they were served their lunch tray. This failure to provide hand hygiene placed Residents' 8, 9, 23, 24, 26, 33, 35, 39, 41, 44, and 97 at increased risk for cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). Findings: During an observation on 3/4/25 at 11:50 a.m. during meal observation in the dining room. Residents' 8, 9, 23, 24, 26, 33, 35, 39, 41, 44, and 97 were seen assisted by staff for lunch and staff placed apron on a couple residents. Staff distributed lunch trays to residents and did not provide or offered hand hygiene to residents eating in the dining room. During a review of Resident 8's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment dated [DATE], the MDS assessment indicated Resident 8's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status) 0-15 scale (0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 8 out of 15 which indicated Resident 8 had moderate cognitive deficit. During a review of Resident 9's MDS assessment dated [DATE], the MDS assessment indicated Resident 9's BIMS assessment score was 11 out of 15 which indicated Resident 9 had moderate cognitive deficit. During a review of Resident 23's MDS assessment dated [DATE], the MDS assessment indicated Resident 23's BIMS assessment score was 7 out of 15 which indicated Resident 23 had moderate cognitive deficit. During a review of Resident 24's MDS assessment dated [DATE], the MDS assessment indicated Resident 24's BIMS assessment score was 6 out of 15 which indicated Resident 24 had severe cognitive deficit. During a review of Resident 26's MDS assessment dated [DATE], the MDS assessment indicated Resident 26's BIMS assessment score was 4 out of 15 which indicated Resident 26 had severe cognitive deficit. During a review of Resident 33's MDS assessment dated [DATE], the MDS assessment indicated Resident 33's BIMS assessment score was 10 out of 15 which indicated Resident 33 had moderate cognitive deficit. (continued on next page)

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	555918	A. Building B. Wing	03/07/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 35's MDS assessment dated [DATE], the MDS assessment indicated Resident 35's BIMS assessment score was 5 out of 15 which indicated Resident 35 had severe cognitive deficit. During a review of Resident 39's MDS assessment dated [DATE], the MDS assessment indicated Resident 39's BIMS assessment score was 15 out of 15 which indicated Resident 39 had no cognitive deficit. During a review of Resident 41's MDS assessment dated [DATE], the MDS assessment indicated Resident 41's BIMS assessment score was 15 out of 15 which indicated Resident 41 had no cognitive deficit. During a review of Resident 44's MDS assessment dated [DATE], the MDS assessment indicated Resident 44's BIMS assessment score was 3 out of 15 which indicated Resident 44 had severe cognitive deficit. During a review of Resident 97's MDS assessment dated [DATE], the MDS assessment indicated Resident 97's BIMS assessment score was 10 out of 15 which indicated Resident 97 had moderate cognitive deficit. During an interview on 3/4/25 at 12:15 p.m. with Certified Nurse Aide (CNA) 8, CNA 8 stated she assisted residents in the dining room for meals but did not provide hand hygiene to residents before serving their lunch tray. CNA 8 stated she should have offered and provided hand hygiene to residents because it was an infection prevention and avoid stomach issues. CNA 8 stated she did not know what activities the residents were doing before they had lunch. During an interview on 3/4/25 at 12:30 p.m. with CNA 9, CNA 9 stated, All residents in the dining room were not provided hand hygiene prior to them eating lunch. CNA 9 stated staff should have offered and provided residents hand hygiene before residents were served lunch. CNA 9 stated residents should have been provided hand hygiene to prevent GI upset (gastrointestinal-discomfort or dysfunction in the gastrointestinal tract). During an interview on 3/5/25 at 12:35 p.m. with Activities Assistant (AA), the AA stated several residents participated activities in the dining room before lunch was served. The AA stated activities involved touching papers, tables and other residents. The AA stated residents did not washed or cleaned their hands after activity and before lunch. The AA stated she did not provide hand hygiene to residents after activity. The AA stated she should have provided and offered hand hygiene to residents to prevent cross contamination and stomach upset. During an interview on 3/7/25 at 9:25 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated residents should be offered and assisted with hand hygiene before residents are served meals. LVN 2 stated it was the responsibility of the staff to ensure hand hygiene are provided to residents before each meal for infection prevention and control and prevent GI upset. During an interview on 3/7/25 at 10:25 a.m. with the Director of Staff Development (DSD), the DSD stated CNAs prepares residents before meals. The DSD stated residents are provided with hand wipes for independent residents and staff helped dependent residents with their hand hygiene to prevent GI upset. (continued on next page)

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	555918	A. Building B. Wing	03/07/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/7/25 at 5:55 p.m. with the Director of Nursing (DON), the DON stated his expectation was for nursing staff, To ensure resident's hands are cleaned and properly positioned and placed in the dining room. The DON stated it was a sanitation issue which could cause GI problem. During a review of facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 2024, the P&P indicated, . All staff are responsible for following all policies and procedures related to the program . All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted . Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedure . During a review of the facility's job description document titled, Dietary Aide, dated 2023, the document indicated, . follows appropriate safety and hygiene measures at all times to protect residents .follows established infection control policies and procedures .as a condition of employment, completes all assigned training and skills competency .maintains food storage areas in a clean and properly arranged manner at all times .assists in inventory and storing in-coming food, supplies, etc., as necessary .

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	555918	A. Building B. Wing	03/07/2025

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51059 Based on observation and interview, during the survey period of 3/4/25 to 3/7/25, the facility failed to provide and maintain a minimum of at least 80 square feet per resident room for 10 out of 16 rooms (Rooms 1, 2, 5, 6, 11, 12, 14, 15, 16 & 17). This failure had the potential to place residents at risk for not having sufficient space to accommodate their needs, privacy, and comfort. Findings: Resident rooms 1, 2, 5, 6, 11, 12, 14, 15, 16 & 17 did not meet the required square footage requirements; however, the residents had privacy. Closets and storage space were adequate. Bedside stands were available. There was sufficient room for nursing care and for residents to ambulate. Wheelchairs and toilet facilities were accessible. The waiver did not adversely affect the health and safety of any of the residents residing in these rooms. Room # Square Feet Number of Residents 1 155.32 sq ft 2 2 157.25 sq ft 2 5 218.41 sq ft 3 6 215.63 sq ft 3 11 218.55 sq ft 3 12 218.01 sq ft 3 14 219.46 sq ft 3 15 157.83 sq ft 2 16 157.54 sq ft 2 17 157.09 sq ft 2 Recommend waiver continue. Don [NAME], HFES Health Facilities Evaluator Supervisor Date Request waiver continue in effect. (continued on next page)

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	555918	A. Building B. Wing	03/07/2025

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	_____

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	03/07/2025

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation and interview, the facility failed to provide a safe, functional, comfortable and homelike environment for residents, staff and the public when: 1. Five of six resident rooms did not have a properly functioning screen doors and one screen door was missing. 2. Three of sixteen resident doors were not functioning properly. These failures had the potential of violating residents' rights to their privacy and at risk of accidents which could lead to serious health condition. Findings: 1. During initial tour a concurrent observation and interview on 3/4/25 at 10:38 a.m. with Resident 42 in his room, Resident 42 was sitting at the edge of his bed. Resident was appropriately dressed and answered questions. Resident 42 stated he had problem with his screen door not working and door to his room was heavy and difficult to closed. Resident 42 stated he reported the concerns to the facility and have not fixed the problem. During a review of Resident 42's Admission Record, dated 3/6/25, the AR indicated Resident 42 was admitted to the facility om 2/6/25 with diagnoses which included muscle weakness and multiple fractures (break in the bones). During a review of Resident 42's Minimum Data Set (MDS-a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 42's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 15 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 42 had no cognitive impairment. During an interview on 3/6/25 at 3:40 p.m. with Certified Nurse Aide (CNA) 5, CNA 5 stated she was not aware the screen doors for Rooms' 15, 16, 17, 1, 2, and 3 were not working properly. CNA 5 stated she did not remember resident, or staff complained about the screen doors not working properly. CNA 5 stated when there was building issues needing to be fixed, she reports to the Maintenance Supervisor (MS) in person or enter into their electronic reporting called TELS (Team Electronic Library System- electronic building management). 2. During a concurrent observation and interview on 3/4/25 at 10:40 a.m. with Resident 40, Resident 40 complained about his door being heavy and difficult to open and closed. Resident stated he reported it but no one had tried to fix it. Resident 40 stated it was difficult for him to open and closed his door. (continued on next page)

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	03/07/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/6/25 at 3:46 p.m. with CNA 6, CNA 6 stated she was not aware of rooms' 15, 1 and 6's door not working properly. CNA 6 stated she did not remember residents or staff complained about rooms' 1, 6 and 15's doors not closing or opening properly. CNA 6 stated she reports building issues to MS in person. CNA 6 stated there was no binder to write building issues needed to be fixed. During a concurrent observation and interview on 3/5/5 at 2:35 p.m. with Maintenance Supervisor (MS), MS walked outside through the sliding door of Resident 40 and checked screen door of Resident 40. The MS stated Resident 40's screen door was not working properly. The MS checked the additional screen doors for Rooms' 16, 17, 1, 2, and 3. The MS stated the screen door for rooms' 16, 17, 1, and 2 were not working properly and room [ROOM NUMBER] did not have a screen door. The MS stated he was not aware room [ROOM NUMBER]'s door was difficult to open and close. The MS stated he was aware of Rooms' 1 and 6's doors were difficult to close and open when the new floors were installed and was in the process of fixing the doors. The MS stated the doors and screen doors should have been working properly because of safety issues which could result in serious health condition. The MS stated he made rounds of the facility at least once a week to ensure facility was safe and doors working properly but did not notice the screen doors were not working properly. During an interview on 3/7/25 at 2:05 p.m. with LVN 3, LVN 3 stated she did not remember any staff or resident complained about screen doors not working properly and missing screen door. LVN 3 stated she was not aware of Rooms' 1, 6 and 15 doors not working properly. LVN 3 stated she reports building issues in person to MS or use TELS system to report issues. During an interview on 3/7/25 at 6:22 p.m. with the Administrator (ADM), the ADM stated her expectation for the MS was to maintain the building. The ADM stated she was not aware the doors and screen doors were not closing or opening properly. ADM stated, All sliding doors should be working properly to keep it as homelike as possible. The ADM stated she was not aware of Rooms' 1, 6 and 15 doors not working properly. The ADM stated it was important to maintain doors in good working condition for safety issue. During a review of facility's policy and procedure (P&P) titled, Safe and Homelike Environment, dated 2024, the P&P indicated, .The facility will provide a safe, clean, comfortable and homelike environment . the physical layout of the facility maximizes resident independence and does not pose a safety risk . Report any furniture in disrepair to Maintenance promptly. Report any unresolved environmental concerns to the Administrator . During a review of the facility's document titled, Maintenance Director, Job Description, dated 2023, the document indicated, . Plans, develops, organizes, implements . Ensures facility remains in compliance with all federal, state and local regulations for Life and Safety Code compliance . Ensures proper planning, direction, participation, and supervision of both preventative and unplanned maintenance and repair activities in the facility, which includes painting, plumbing, carpentry . Develops and implements preventative maintenance tasks, document instructions an procedures for the preventative maintenance of facility .