

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555918	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER Fowler Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of ten sampled residents (Resident 15) were assessed to self-administer and store medications at bedside when Resident 15 had a bottle of [brand name Carboxymethylcellulose Sodium 1%/Glycerin 0.9% (over the counter eye drop medication used to treat dry eyes)] eye drops stored at bedside for self-administration with no order or Medication Self-Administration Assessment Form (MSA- an assessment form to determine if a resident is clinically appropriate to safely and securely store and self-administer their own medication at bedside).This failure resulted in Resident 15 self-administering and storing medication at bedside without oversight which could lead to duplicate therapy, medication interactions and adverse effects.Findings:During an observation on 6/29/26 at 8:49 a.m. in Resident 15's room, Resident 15 was observed sitting up in bed. Resident 15 had a clear bin on his bedside nightstand with [brand name Carboxymethylcellulose Sodium 1%/Glycerin 0.9%] eye drops visible.During an observation on 6/29/26 at 3:04 p.m. in Resident 15's room, Resident 15 was observed sitting up in bed. Resident 15 had a clear bin on his bedside nightstand with [brand name Carboxymethylcellulose Sodium 1%/Glycerin 0.9%] eye drops visible.During a concurrent observation and interview on 6/29/26 at 3:13 p.m. with Licensed Vocational Nurse (LVN) 2, in Resident 15's room, Resident 15 was observed sitting up in bed. Resident 15 had a clear bin on his bedside nightstand with [brand name Carboxymethylcellulose Sodium 1%/Glycerin 0.9%] eye drops visible. LVN 2 stated Resident 15 had eye drop medication at bedside. Resident 15 stated the eye drops were his and he self-administered them at bedside.During a concurrent interview and record review on 6/29/26 at 3:25 p.m. with LVN 2, Resident 15's electronic medical record (eMAR), dated 6/29/26, was reviewed. LVN 2 stated Resident 15 was confused and confused residents were not candidates to safely and securely store and/or self-administer medication at bedside. LVN 2 stated Resident 15 did not have a provider order for [brand name Carboxymethylcellulose Sodium 1%/Glycerin 0.9%] eye drops. LVN 2 stated Resident 15 did not have provider orders, a Medication Self-Administration Assessment Form (MSA), or a care plan to store and/or self-administer [brand name Carboxymethylcellulose Sodium 1%/Glycerin 0.9%] eye drops at bedside. LVN 2 stated all medications required a provider order. LVN 2 stated all medications stored and self-administered at bedside required a provider order, a care plan, and a MSA to ensure oversight. LVN 2 stated Resident 15 was at risk for duplicate therapy, medication interactions and adverse effects when he stored and self-administered [brand name Carboxymethylcellulose Sodium 1%/Glycerin 0.9%] eye drops at bedside without an order or MSA. During an interview on 7/2/26 at 9:46 a.m. with the Director of Nursing (DON), the DON stated Resident 15 was confused and not an appropriate candidate to safely and securely store and/or self-administer medications at bedside. The DON stated Resident 15 did not have an order for [brand name Carboxymethylcellulose Sodium 1%/Glycerin 0.9%] eye drops. The DON stated Resident 15 did (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not have a MSA or care plan completed to store and self-administer [brand name Carboxymethylcellulose Sodium 1%/Glycerin 0.9%] eye drops at bedside. The DON stated Resident 15 was placed at risk for duplicate therapy, medication interactions, adverse effects and infection from improper eye drop medication administration. The DON stated the facility was responsible for identifying hazards and accidents to ensure resident safety, which included medication stored and self-administered at bedside. The DON stated facility policy and procedures were not followed when Resident 15 had an unidentified medication at bedside with no order, MSA, or care plan which posed a potential risk to Resident 15's safety. During a review of Resident 15'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), dated 6/30/26 the AR indicated Resident 15 was admitted to the facility on [DATE] with diagnoses of dementia (decline in ability to think), muscle weakness, and encephalopathy (decline in brain function). During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 5/11/26, the MDS indicated Resident 15 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 10 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 15 was moderately cognitively impaired. During a review of the facility's policy and procedure (P&P) titled, Resident Self-Administration of Medication, dated 2026, the P&P indicated, . a resident may only self-administer medication after the facility's interdisciplinary team has determined which medication may be self-administered safely. the results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record. the following conditions are met for bedside storage to occur. the manner of storage prevents access by other residents. all nurses and aides are required to report to the charge nurse on duty medication found at the bedside not authorized for bedside storage. During a review of the facility's P&P titled, Accidents and Supervision, dated 2025, the P&P indicated, . the resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accident. This includes. identifying hazard(s) and risk (s). all staff. are to be involved in observing and identifying potential hazards in the environment. various sources provide information about hazards and risks in the resident environments. these sources may include, but are not limited to. environmental rounds. individual observation.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review the facility failed to meet professional standards of practice for one of ten sampled residents (Resident 41) when Resident 41's physician's order for physical therapy referral was not followed. This failure resulted in Resident 41's physician's order for a physical therapy referral not being implemented, from 3/2/226 to 6/29/26, which could lead to delays in care. Findings: During a concurrent observation and interview on 6/29/26 at 10:02 a.m. with Resident 41, in Resident 41's room, Resident 41 stated he previously received physical therapy services and had been transitioned to the Restorative Nursing Program for ongoing therapy services. Resident 41 stated his provider placed a new physical therapy referral and he had not seen the physical therapist. Resident 41 could not state the date the provider placed the physical therapy referral. During a concurrent interview and record review on 6/30/26 at 11:45 a.m. with the Director of Rehabilitation (DOR), Resident 41's Physical Therapy Notes, dated 6/30/26, were reviewed. The DOR stated physical therapy had not received a referral for Resident 41. The DOR stated physical therapy had not seen Resident 41 since 3/2025, when he completed his therapy service period. The DOR stated a provider could place a physical therapy referral order if requested by the resident or care team for mobility progress. The DOR stated after a provider placed a physical therapy referral, licensed nursing staff were responsible for relaying the referral to the physical therapy department and the physical therapy department would then arrange a date and time to assess the resident, despite insurance coverage. The DOR stated after the resident was assessed, physical therapy would make recommendations for physical therapy, if applicable, and send the request to insurance. During a concurrent interview and record review on 6/30/26 at 10:51 a.m. with the Director of Nursing (DON), Resident 41's electronic medical record (eMAR), dated 6/30/26, was reviewed. The DON stated on 3/2/26 Resident 41 had an order for physical therapy referral. The DON stated Resident 41's physical therapy referral, on 3/2/26, was not sent to the DOR or the physical therapy department. The DON stated there was no documentation or assessment to indicate physical therapy had assessed Resident 41, as per provider orders. During an interview on 7/2/26 at 9:46 a.m. with the DON, the DON stated Resident 41 had a physical therapy referral order on 3/2/26 that was not implemented. The DON stated clinical nursing staff were responsible for ensuring new orders were implemented. The DON stated facility policy and procedure were not followed when Resident 41's provider orders were not followed. The DON stated Resident 41 was at risk for physical mobility decline and delay in plan of care when provider orders were not followed. During a review of the facility's Policy and Procedure (P&P) titled, Telephone/Verbal Orders, dated 2026, the P&P indicated, .follow through with orders by making appropriate contact or notifications .During a review of the facility's P&P titled, Therapy Evaluation, dated 2025, the P&P indicated, .the Licensed Therapist will perform an initial resident evaluation upon physician referral and any re-evaluation where indicated. the Rehabilitation Department will be notified when a physician order is written for therapy. the Licensed Therapist will perform a chart review and initiate the evaluation. evaluations will be documented. During a review of the facility's P&P titled, Reporting of Therapy Services, dated 2025, the P&P indicated, .all specialized rehabilitation services are provided in accordance with physician orders. During a review of the professional reference titled, A Grounded Theory of the Implementation of Medical Orders by Clinical Nurses, retrieved from, https://pmc.ncbi.nlm.nih.gov/articles/PMC10863222/, dated 2/13/24, the professional reference indicated, .The implementation of medical orders is a crucial responsibility for clinical nurses, as they bear legal accountability for the precise implementation of directives issued by medical practitioners.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview and record review the facility failed to ensure the daily nurse staffing information publicly posted accurately reflected actual nursing staffing hours. The facility posted projected nursing staffing hours. This deficient practice had the potential to affect all 42 residents residing in the facility upon entrance. This failure had the potential to prevent residents, resident representatives and visitors from accessing accurate daily nurse staffing information intended to inform the public of the facility's actual nurse staffing levels. Findings: During an observation on 6/29/26 at 8:01a.m., the daily nurse staffing information was posted in the facility. The posted document was dated Friday, June 26, 2026. The posting identified a projected resident census of 41, projected staff hours of 156, and a projected Nursing Hours Per Patient Day (NHPPD) of 3.80. The posting reflected projected staffing information for the day rather than the previous day's actual hours worked. No posting reflecting the actual hours worked for the previous day was observed. During an interview on 7/2/26 at 1:07 p.m., with the Director of Staff Development (DSD), the DSD stated he was responsible for preparing and posting the daily nurse staffing information using the daily census and staff schedules. The DSD stated he typically prepared the posting the night before and updated it as needed for staffing changes. The DSD stated the posted staffing information reflected the projected staffing hours for the current day. The DSD further stated the previous day's actual staffing information was maintained behind the current posting. During a concurrent observation of the staffing posting location with the DSD, the previous day's staffing information was not observed behind the current posting. The DSD stated the Human Resources staff member had likely removed the previous day's posting for filing. The DSD stated if staff called in sick or left early, the posting generally remained unchanged because coverage was usually obtained. If coverage could not be secured, he recalculated the staffing hours and posted a revised document. The DSD stated his understanding was that the daily nurse staffing information was required to be posted daily, be accurate, and reflect the current resident census. During an interview on 7/2/26 at 9:37 a.m., with the Director of Nursing (DON), the DON stated the DSD was responsible for preparing and posting the daily nurse staffing information. The DON stated the daily staffing information was expected to be posted each day and that both the projected staffing hours and actual nursing staffing hours were to be posted. When informed the staffing information observed on 6/29/26 reflected Friday's staffing information, the DON stated the posting had not been updated because the DSD had not yet posted the current day's information. The DON further stated the facility only posted projected nursing staffing information and that actual nursing staffing hours were not publicly posted. The DON stated Human Resources verbally communicated the actual nursing staffing hours during the daily stand-up meeting. When asked if she was aware of the facility's written policy directed staff to post projected nursing staffing information rather than actual nursing staffing hours, the DON stated she was not aware the policy referred to projected staffing information. When asked if she was aware the federal requirement was to publicly post actual nursing staffing hours, the DON stated she believed the requirement was to post projected nursing staffing information. The surveyor reviewed Appendix PP, SOM, F732 and 42 CFR S 483.35(g) with the DON. Following review, the DON verbalized understanding that the federal regulation required facilities to publicly post actual nursing staffing hours. The DON further stated that if a resident or family member wanted to know the actual nursing staffing hours, they would have to ask a staff member because the actual nursing staffing hours were not publicly posted. The DON stated it was important for residents and family members to have access to the staffing information so they could know the facility had sufficient staffing to provide (continued on next page)		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident care.During a review of facilities policy and procedure (P&P) titled, Nurse Staffing Posting Information, dated 2025, the P&P indicated, The nurse staffing sheet will be posted on a daily basis and will contain the following information: d. the total number and projected hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift.According to the Electronic Code of Federal Regulations (eCFR), Title 42, Chapter IV, Subchapter G, Part 483.35(g), facilities must publicly post daily nurse staffing information, including the actual hours worked by registered nurses, licensed vocational/practical nurses, and certified nurse aides.Electronic Code of Federal Regulations (eCFR). (2026). Title 42-Public Health, Chapter IV, Subchapter G, Part 483-Requirements for States and Long-Term Care Facilities, S 483.35(g), Nurse Staffing Information. National Archives and Records Administration. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services on acquiring, receiving, dispensing, and administering of all drugs to meet the needs of each residents for one of five sampled residents (Resident 13) when Licensed Vocational Nurse (LVN) 1 did not administer physician ordered apixaban (medication used to prevent blood clots [clumps of blood that can block the blood flow through the body]) 5 milligrams (mg-a unit of measurement that was used to show a very small amount of a medication) twice daily on 7/1/26. LVN 1 was aware of the unavailability of Apixaban and did not notify the pharmacy. This failure resulted in Resident 13 not administered physician ordered apixaban and placed Resident 13 at potential risk for sub-therapeutic medications level and subsequent blood clot formation, which could lead to stroke (blood flow to the brain is blocked) and deep vein thrombosis (formation of blood clots in the legs). Findings: During an observation on 7/1/26 at 8:11a.m. during the medication administration observation task, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 13's scheduled apixaban was being held because it was not available in the medication cart. LVN 1 administered the remainder of Resident 13's scheduled morning medications. LVN 1 documented in Resident 13's electronic health record that the scheduled dose of apixaban was not administered. During a review of Resident 13's admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the admission record indicated, Resident 13 was admitted to the facility on [DATE] with a diagnosis which included morbid obesity (had a very high amount of body fat), difficulty walking, heart failure (the heart did not pump blood as well as it should), atrial fibrillation (the heart beat with an irregular rhythm [the heart did not beat in a steady pattern]), and peripheral vascular disease (the blood vessels outside the heart became narrowed and reduced blood flow). During a review of Resident 13'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 13'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 13 out of 15 which indicated Resident 13 had no cognitive deficit. During a review of Resident 13's Order Summary Report, dated July 2026, the Order Summary Report indicated, Resident 13's apixaban oral tablet 5mg oral tablet was ordered to be administered by mouth two times daily. During a concurrent interview and review of Resident 13's electronic health record on 7/1/26 at 8:49 a.m. with LVN 1, LVN 1 stated Resident 13's last dose of apixaban was administered on 6/30/26 at 4 p.m. LVN 1 confirmed Resident 13 was scheduled to receive apixaban twice daily at 8 a.m. and 4 p.m. LVN 1 confirmed Resident 13 did not receive the scheduled 8 a.m. dose because the medication was not available. LVN 1 stated if the facility was completely out of a medication, the pharmacy could be contacted to obtain the medication for the resident's evening dose. LVN 1 stated it was the responsibility of every nurse to ensure medications were ordered and available, and it was important for residents to receive their medications as scheduled. LVN 1 stated apixaban was important for Resident 13 because it was prescribed for anticoagulation (to help prevent blood clots from forming). LVN 1 stated the risk of Resident 13 not receiving the medication as scheduled included blood clots or the medication not remaining at a therapeutic level. During an interview on 7/1/26 at 3:34 p.m. with the Director of Staff Development/Minimum Data Set Nurse (DSD/MDSN), the DSD/MDSN stated if a (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication was not available when it was time to administer, the nurse would contact the pharmacy to request a stat [immediately] order and contact the physician to obtain a stat order, if needed. The DSD/MDSN stated the facility's process for obtaining a medication not in stock was to contact the physician, obtain a one-time order of the medication and administer it to the resident. The DSD/MDSN stated nursing staff were responsible for submitting medication refill requests by attaching the medication sticker to the refill document and faxing it to the pharmacy. The DSD/MDSN stated nursing staff were expected to follow up with the pharmacy regarding refill requests. The DSD/MDSN stated when a resident missed a scheduled medication due to the medication not being available, the missed dose would be documented on the Medication Administration Record (MAR) as unavailable, in the medication administration notes, and a progress note would be completed. The DSD/MDSN stated it was important for residents to receive medications as ordered by the physician. The DSD/MDSN stated apixaban was an anticoagulant and it was important for the medication to be administered as ordered to Resident 13. During an interview on 7/2/26 at 9:29 a.m. with the Director of Nursing (DON), the DON stated when Resident 13 prescribed medication, such as apixaban, was unavailable at the scheduled administration time, nursing staff were expected to first check the emergency medication kit (e-kit). The DON stated if medication was not available in the e-kit, nursing staff were expected to contact the physician and the pharmacy to obtain a stat order. The DON stated nursing staff were expected to notify Resident 13 and the responsible party (RP) regarding the unavailable apixaban medication. The DON stated nursing staff were expected to reorder medications when they reached the last row of the bubble pack to ensure an adequate medication supply was maintained. The DON stated when a scheduled medication was unavailable, nursing staff were expected to document the medication as unavailable, document the physician and pharmacy had been contacted, document the resident and RP had been notified, and document the anticipated arrival time of the medication. The DON stated the facility monitored medications that were running low by checking medication carts, conducting random audits to verify medications had been reordered, and providing in-service education to nursing staff regarding timely medication reordering. The DON stated medications could be ordered through the electronic health record or by faxing the order to the pharmacy. The DON stated nursing staff could also check the e-kit and obtain an emergency supply when appropriate. The DON stated it was important for Resident 13 to receive prescribed apixaban medications as ordered to reduce the risk of complications. The DON stated if Resident 13 stopped taking apixaban, Resident 13 could experience coagulation issues (problems with the blood clotting normally) and could experience an adverse reaction if the medication was stopped abruptly. During a review of the facility's Policy and Procedure (P&P) titled, Ordering and Receiving Non-Controlled Medications, 2010, the P&P indicated, timely delivery of new orders is required so that medication administration is not delayed. promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor. During a review of the facility's Policy and Procedure (P&P) titled, Unavailable Medications, 2026, the P&P indicated, the facility shall follow established procedures for ensuring residents have a sufficient supply of medications.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was stored and served safely in accordance with professional standards of food service safety for 41 out of 41 residents eating at the facility when six loafs of unopened bread were not labeled of a use by date (is the deadline after which a product may no longer be safe to use) and a opened 2.26 kilogram (kg-a unit of measurement) canister of sour cream was retained past its use by date. This failure placed residents who consumed food from the kitchen at potential risk to be exposed to foodborne illness (food poisoning). Findings: During a concurrent observation and interview on 6/29/26 at 8:04 a.m. with the Certified Dietary Manager (CDM), in the kitchen, an opened 2.26 kg canister of sour cream was observed labeled with an open date of 6/20/26 and a use by date of 6/27/26. The label indicated the sour cream was 2 days past the use by date. The CDM stated sour cream was a dairy product and per facility policy and procedure all dairy products needed to be used within 7 days of opening. The CDM stated the canister of sour cream had been expired for 2 days and retained within the kitchen. The CDM stated it was important not to retain expired food items in the kitchen to prevent accidental serving of expired food items to residents which could result in foodborne illness. The CDM stated all kitchen staff were responsible for ensuring expired food items were removed on their use by date. During a concurrent observation and interview on 6/29/26 at 8:11 a.m. with the CDM, in the kitchen, six loafs of unopened bread were observed with no labels. The CDM stated the six loafs of bread did not have a label to indicate received by or use by dates. The CDM stated it was important to label all food items to ensure food was rotated on a first in, first out cycle and prevent the serving of expired food items which could result in foodborne illness. During an interview on 6/30/26 at 11:27 a.m. with the Registered Dietician (RD), the RD stated all food items were expected to be labeled with received, opened and use by dates, per facility policy and procedure. The RD stated it was important to label all food items to ensure food was rotated on a first in, first out cycle to prevent expired food items from being served. The RD stated all kitchen staff were responsible for ensuring food items were labeled, per facility policy and procedure, before being stocked on the shelves. The RD stated if food items were not labeled and retained past their use by date there was a risk expired food items would be served to residents. The RD stated consuming expired food items could lead to food borne illness. During an interview on 7/2/26 at 9:28 a.m. with the Director of Nursing (DON), the DON stated kitchen staff were expected to adhere to food safety standards of practice and facility policy and procedure, which included labeling all food items with received, opened and use by dates, and discarding expired food items by the use by date. The DON stated food safety standards of practice and facility policy and procedure were not followed when six loafs of unopened bread were not labeled with a received or use by date and a canister of sour cream was retained 2 days past its use by date. The DON stated residents were placed at risk of being served expired food items which could result in foodborne illness. During a review of the facility's document titled, Diet Type Report, dated 7/7/26, the document indicated 41 residents received meals from the kitchen. During a review of the facility's policy and procedure (P&P) titled, Date Marking for Food Safety, dated 2026, the P&P indicated, the facility adhere to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety of food. the food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. the discard day or date may not exceed the manufacturer's use-by-date, or four days, whichever is earliest. The date of opening or preparation counts as day 1. the Head Cook, or designee, shall be responsible for checking the refrigerator daily (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for food items that are expiring, and shall discard accordingly.During a review of the facility's P&P titled, Food Safety Requirements, dated 2026, the P&P indicated, .labeling, dating, and monitoring refrigerated food, including but not limited to leftovers, so it is used by its use-by-date, or frozen (where applicable)/discarded.During a review of the facility's P&P titled, Dry Storage Guidelines, undated, the P&P indicated, .bread 5-7 days.During a review of the facility's P&P titled, Refrigerator Storage Guide, undated, the P&P indicated, .dairy products.after opening it may be used for a maximum of 7-days.sour cream.opened: max. of 7 days.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555918	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER Fowler Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8448 East Adams Avenue Fowler, CA 93625	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility failed to ensure infection prevention and control practices were followed for cleaning and disinfecting shared resident care equipment for two of five sampled residents (Resident 13 and 6) when Licensed Vocation Nurse 1 used a blood pressure cuff (a medical equipment used to measure blood pressure) to assess Resident 13, and utilized the same blood pressure cuff for Resident 6 without cleaning or disinfecting the device between residents. This failure had the potential risk for Resident 13 and Resident 6 to be exposed to cross-contamination (the unintended transmission of infectious organisms) through shared resident care equipment. Findings: During an observation on 7/1/26 at 8:11a.m., during the medication administration task, Licensed Vocational Nurse (LVN) 1 stated she was going to obtain Resident 13's blood pressure. LVN 1 retrieved a blood pressure cuff from the bottom drawer of the medication cart and obtained Resident 13's blood pressure. After obtaining the blood pressure, LVN 1 returned to the medication cart and placed the used blood pressure cuff on top of the medication cart. After completing medication administration for Resident 13, LVN 1 stated she needed to retrieve a vitamin supplement from another medication stockroom because it was not available in the medication cart. Prior to leaving the medication cart, LVN 1 placed the used blood pressure cuff into the bottom drawer of the medication cart and locked the cart. LVN 1 returned to the medication cart with the supplement, unlocked the cart and stated she was going to administer medications to Resident 6. LVN 1 retrieved the same blood pressure cuff from the bottom drawer of the medication cart without cleaning or disinfecting. LVN 1 entered Resident 6's room and used the same blood pressure cuff to obtain Resident 6's blood pressure. During an interview on 7/1/26 at 8:49 a.m. with LVN 1, LVN 1 stated she would normally clean the blood pressure cuff on all sides, wrap it in a disinfectant wipe, and use another blood pressure cuff while allowing the used cuff to remain wet for the required contact time. LVN 1 stated, I forgot to do that process today. I was nervous. LVN 1 further stated it was important to ensure equipment was clean and sanitary before resident use to promote proper hygiene and resident safety. During an interview on 7/1/26 at 9:16 a.m. with the Infection Preventionist (IP), the IP stated staff were expected to clean shared resident care equipment, including blood pressure cuffs, between resident use using the purple disinfectant wipes and allow the blood pressure cuffs to air dry. The IP stated staff received education on cleaning shared resident care equipment through in-service training and ongoing reminders. The IP stated if staff were observed failing to disinfect equipment between resident use, they would be reeducated on the proper cleaning process and required to demonstrate competency. The IP further stated it was important to disinfect blood pressure cuffs between resident use because organisms could be transferred from one resident to another, resulting in spread of infection. During an interview on 7/1/26 at 3:34 p.m. with the Director of Staff Development/Minimum Data Set Nurse (DSD/MDSN), the DSD/MDSN stated staff were expected to clean blood pressure cuffs between resident use using the facilities purple Sani wipes. The DSD/MDSN stated the Sani wipes required a two-minute contact time and the facility had two blood pressure cuff available so staff could alternate their use while allowing the disinfectant to remain on the cuff for the required contact time. The DSD/MDSN further stated it was important to clean blood pressure cuffs between resident use to reduce the risk of infection transmission between residents. During an interview on 7/2/26 at 9:29a.m. with the Director of Nursing (DON), the DON stated staff were expected to clean and disinfect shared resident care equipment, including blood pressure cuffs, between resident use using Sani wipes and allow the disinfectant to remain on the equipment for a two minute contact time before using it with another resident. The DON stated the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility monitored compliance by conducting rounds, during which the IP observed staff performing equipment cleaning and hand hygiene practices. The DON stated nursing staff received education on cleaning shared resident care equipment through in-service training. The DON if a staff member was observed failing to clean equipment between resident use, the staff member would be reeducated. The DON further stated if the behavior became a pattern, disciplinary action would be taken. The DON stated it was important to properly clean shared resident care equipment between resident use to prevent the spread of infection. During a review of facilities policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Equipment, dated 2025, the P&P indicated, reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection. reusable multiple-resident items are items that may be used multiple times for multiple residents. Examples include stethoscopes, blood pressure cuffs, feeding tube pumps, and oxygen concentrators. each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident. multiple-resident use equipment shall be cleaned and disinfected after each use. During a review of facilities policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 2025, the P&P indicated, all reusable items and equipment requiring special cleaning, disinfection or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment.		