STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055204	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2024
NAME OF PROVIDER OR SUPPLIER: Oakwood Gardens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 3510 East Shields Fresno, CA 93726	

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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123 Based on interview and record review, the facility failed to implement their admissions policy and procedure for one of three sampled residents (Resident 1) when the facility admitted Resident 1 from the general acute care hospital (GACH) for intravenous (IV-within a vein) antibiotics (medication that fight bacterial [small organism which can cause disease] infections) therapy and the facility did not have registered nurse (RN) on duty to administer the IV antibiotic medication. This failure resulted in Resident 1 not receiving his prescribed IV antibiotic medication and Resident 1 had to be transported back to the GACH just 3 hours after being admitted to the facility. Findings: During a telephone interview on 7/3/24 at 5:02 p.m. with Family Member (FM) 1, FM 1 stated Resident 1 was transferred from the GACH and admitted to the skilled nursing facility for IV antibiotics therapy. FM 1 stated shortly after Resident 1's admission, she received a phone call from the charge nurse informing her the facility did not have an RN on duty to administer the IV antibiotic. FM 1 stated the facility did not provide the services they had said they were capable of, and Resident 1 had to be sent back to the GACH within hours of admission. During a review of Resident 1's Order Summary Report (OSR), dated 6/7/24, the OSR indicated, . Vancomycin HCl [hydrochloride-a salt used to help medication dissolve in liquid] Intravenous Solution [an antibiotic used to treat resistant strains of bacteria] . 750 MG [milligrams-unit of measurement] . Use 167 ml [milliliters-unit of liquid measurement] intravenously every 12 hours for Bacteremia [presence of bacteria in blood] MRSA [methicillin-resistant Staphylococcus aureus-a type of bacteria resistant to certain antibiotics] for 3 Days . During a review of Resident 1's Admission Record, (AR-document containing resident demographic information and medical diagnosis), undated, the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses which included disease of anus (opening of the rectum) and rectum (end part of the large intestine), bacteremia (presence of bacteria in blood), dementia (impaired ability to remember, think, or make decisions), major depressive disorder (low or depressed and a loss of interest in activities), and anxiety (feeling or fear, dread, and uneasiness that may occur as a reaction to stress). (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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Gardens Care Center	3510 East Shields Fresno, CA 93726

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Residents 1's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 10 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1's cognition was moderately impaired. During a concurrent interview and record review on 7/8/24 at 11:22 a.m. with the Minimum Data Set Coordinator (MDSC), Resident 1's Nurse's Note, dated 6/7/24 at 9:23 p.m. was reviewed. The Nurse's Note indicated, . sent resident to [name of GACH] because she had an IV medication, Vancomycin HCL . due at 2000 [8:00 p.m.] that was not available and also no RN would have been available to administer it . EMT's from [name of ambulance company] left with resident at 1950 [7:50 p.m.] . Writer notified D.O.N. [Director of Nursing] at 1918 [7:18 p.m.] about the order and she called back and said to send resident to hospital . The MDSC stated she did not know why an RN was not available to administer the antibiotic medication. During a telephone interview on 7/8/24 at 3:03 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he was the charge nurse on 6/7/24 when Resident 1 was admitted . LVN 1 stated Resident 1 arrived at the facility around 5:30 p.m. and was due for her IV medication at 8:00 p.m. LVN 1 stated there were no RNs on duty to administer the medication. LVN 1 stated he called the Director of Nursing (DON) and was instructed to send the resident back to the hospital because there were no RNs available. LVN 1 stated he notified Resident 1's responsible party and the nurse practitioner (NP) the facility was unable to administer the IV medication and Resident 1 was being transferred back to the GACH. During an interview on 7/15/24 at 2:07 p.m. with the DON, the DON stated Resident 1 was admitted on [DATE] for IV antibiotics and the facility did not have an RN available to administer the 8:00 p.m. dose. The DON stated she was not aware Resident 1's IV antibiotic was ordered every 12 hours prior to her admission. The DON stated she attempted to find an RN to administer the medication but was unsuccessful and Resident 1 was sent back to the GACH. During a telephone interview on 7/15/24 at 3:59 p.m. with LVN 2, LVN 2 stated she was Resident 1's admission nurse on 6/7/24. LVN 2 stated she had received Resident 1's orders and report from the hospital after Resident 1 was transferred to the facility. LVN 2 stated Resident 1 had an order for IV vancomycin every 12 hours and the next dose was due in a couple of hours after her admission. During a telephone interview on 7/15/24 at 4:11 p.m. with the NP, the NP stated the charge nurse contacted her on 6/7/24 and notified her Resident 1 had an order for IV vancomycin but there were no RNs to administer the medication. The NP stated she was concerned Resident 1 not receiving the IV antibiotics and decided it would be safe to send Resident 1 back to the GACH instead of missing an antibiotic dose. During a telephone interview on 7/16/24 at 5:06 p.m. with the Marketing Director/Admissions (MDA), the MDA stated she had received Resident 1's referral from the GACH which indicated Resident 1 was on IV antibiotics every 12 hours. The MDA stated when Resident 1 arrived at the facility from GACH and there was no RN on duty to administer the IV antibiotic medication. The MDA stated Resident 1 should not have been transferred to the facility since there were no RNs available to administer the IV antibiotic medication. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 7/31/24 at 11:22 a.m. with the Administrator (ADM), the ADM stated Resident 1 was admitted to the facility for IV antibiotics. The ADM stated the facility did not have an RN available to administer Resident 1's IV antibiotic and Resident 1 was transferred back to the GACH. During a review of the facility's job description titled Admissions Director, dated 1/2019, indicated, . Reports to . Administrator and Director of Nursing . Primary purpose of your job is to plan and coordinate admission to the facility . Completes resident intake process. Coordinates with Director of Nursing and/or Case Manager to assure appropriateness of facility admissions . During a review of Resident 1's GACH document titled Discharge Summary (DS), dated 6/7/24, the DS indicated, . admitted . 5/26/24 . Hospital Diagnosis . MRSA bacteremia [presence of bacteria in your blood] . DISCHARGE MEDICATION LIST . vancomycin 750 mg/250 mL solution IVPB [IV piggy back-small bag of solution given IV] . every 12 (twelve) hours for 3 days . Discharging to: Skilled Nursing Facility . Destination [name of SNF] . During a review of the facility's policy and procedure (P&P) titled Admissions Policies, dated 12/2006, the P&P indicated, . primary purpose of our admission policies is to establish uniform guidelines for personnel to follow in admitting residents to the facility . Our admission policies apply to all residents admitted to the facility . The objectives of our admission policies are to . Admit residents who can be adequately cared for by the facility .