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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>055204 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>04/22/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Oakwood Gardens Care Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3510 East Shields<br>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.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38961</p> <p>Based on interview, and record review the facility failed to ensure compliance with its policies and procedures regarding resident appointment coordination and verification for one of three sampled residents (Resident 1), when Resident 1 was mistakenly prepared and transported to a medical appointment that was not scheduled for her.</p> <p>This failure resulted in unnecessary physical and emotional distress to Resident 1 and potentially exposed to inappropriate treatment or risk.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR- a document containing resident medical and personal information), dated 4/22/25, the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included, unspecified nondisplaced fracture of fifth cervical vertebrae, unspecified fracture of right acetabulum (concave surface of the of the pelvis), age related Osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Residents 1's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment, undated, indicated Resident 1's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 9 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 was moderately impaired.</p> <p>During a phone interview on 4/21/25 at 12:03 p.m., with Resident 1's Family Member (FM), FM stated, she was the person responsible for Resident 1's care. FM stated Resident 1 had a fall at home on 2/21/25 and was admitted to the skilled nursing facility on 2/22/25. FM stated she was not told that Resident 1 had an appointment at the cancer treatment center. FM stated the facility took Resident 1 to an appointment that was not meant for her. FM stated she spoke to Resident 1 who became upset and started to cry. FM stated Resident 1 did not have cancer and did not want cancer treatment because she did not want to die.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During a concurrent interview and record review on 4/22/25 at 8:50 a.m., with the Director of Nursing (DON), the DON reviewed the facility document titled, Order List Report dated 4/22/25. The DON stated the Order list Report shows all scheduled and upcoming appointments for all residents. The DON stated according to the report, there were two residents scheduled for appointments on 2/27/25, but Resident 1 was not one of them. The DON stated Resident 3 and Resident 4 were the ones who had appointments scheduled on 2/27/25. The DON stated Resident 3 was on bed C and shared a room with Resident 1 who was bed A. The DON stated the WC was responsible for putting together the daily list of appointments. The DON stated the Orders List Report are kept at the nurse's station and added to the transport log. The DON stated nursing staff were supposed to check the list every day and make sure the right residents are dressed and ready for the appointments but did not. The DON stated on 2/27/25 the WC mistakenly told staff Resident 1 had an appointment, and staff got Resident 1 ready and sent her out for the appointment.</p> <p>During an interview on 4/22/25 at 9:15 a.m., with the [NAME] Clerk (WC), the WC stated she was responsible for tracking all follow up appointments for residents. The WC stated she reviewed documents for all new admissions and schedule follow up appointments. The WC stated it was her responsibility to inform the nursing staff daily for schedule appointments. The WC stated on 2/27/25 she did not tell the nurse Resident 1 had an appointment. The WC stated she did not schedule an appointment for Resident 1 on 2/27/25.</p> <p>During an interview and record review on 4/22/25 at 10:30 a.m., with licensed vocational nurse (LVN) 1, Resident 1's Medical Records, (MR- a collection of information about a person's health) was reviewed. LVN 1 stated Resident 1 was admitted to the facility on [DATE] and does not have a cancer diagnosis. LVN 1 stated Resident 1 had fractures on her neck and pelvis before coming to the facility and helping her out of bed and getting her dressed for an appointment could have caused more pain. LVN 1 stated there was a list at the nurse's station of residents who have appointments, and staff were supposed to review this list at the beginning of the shift. LVN 1 stated staff should also print a copy of the resident's face sheet and doctor's orders to take with them to the appointment. LVN 1 stated it was the nursing staff's responsibility to make sure the right resident goes to the right appointment, with the right documents, and the correct location. LVN 1 stated she was the nurse assigned to Resident 1 on 2/27/25. LVN 1 stated she did not take the necessary steps to ensure the right resident was sent for the appointment.</p> <p>During an interview on 4/22/25 at 12:20 p.m., the Director of Nursing (DON), The DON stated she spoke with nursing staff about the incident that happened on 2/27/25. The DON stated the nursing staff told her the WC informed them Resident 1 had an appointment on 2/27/25 and needed to be up and dressed. The DON stated the nursing staff helped Resident 1 get dressed. The DON stated Resident 1 was prepared for an appointment that was not scheduled for her. The DON stated the appointment was actually for Resident 3. The DON stated the cancer clinic identified the wrong resident had been sent to the appointment and the clinic notified us. The DON stated we arranged transport for Resident 3 to the clinic. The DON stated the LVN assigned to Resident 1 should have printed Resident 1's face sheet, current doctor's orders, and appointment location. The DON stated LVN's are responsible for making sure the right resident goes to the right appointment with the correct documents and the correct place. The DON stated the WC was responsible for making all transport arrangements. The DON stated the staff did not follow proper procedure for sending resident to appointments, as a result Resident 1 was mistakenly taken to an appointment. The DON stated the incident should not have happened.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 4/22/25 at 1:25 PM, the Administrator (ADM), the ADM stated the incident on 2/27/25, where Resident 1 was mistakenly sent to an appointment she wasn't scheduled for, should never have happened. The ADM stated this should not happen to any resident. The ADM stated the appointment was actually for Resident 1's roommate. The ADM stated the staff did not follow the facilities policies and procedure.</p> <p>During a review of the facility's Policy and Procedure (P &amp; P), titled, Transportation dated December /2008, the P&amp;P indicated . Our facility shall help arrange transportation for residents as needed . [NAME] Clerk will help the resident as needed to obtain transportation .</p> <p>During a review of the facility's P &amp; P titled, Transfer or Discharge, Resident-Initiated, dated 2001, the P&amp;P indicated . If the resident is being transferred, and return is expected, the following information is conveyed to the receiving provider:</p> <ul style="list-style-type: none"> <li>a. Contact information of the practitioner who was responsible for the care of the resident;</li> <li>b. Resident representative information, including contact information;</li> <li>c. Advance directive information;</li> <li>d. All special instructions and/or precautions for ongoing care, as appropriate such as: <ul style="list-style-type: none"> <li>(1) treatments and devices (oxygen, implants [medical device or object inserted into the body], IVs [intravenous-delivering fluids or medications directly into the veins], tubes/catheters [a medical device use to access or drain areas of the body]);</li> <li>(2) transmission-based precautions such as contact, droplet, or airborne [infection control measures use in healthcare to prevent the spread of infections]; and special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precaution .</li> </ul> </li> </ul> |