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 01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Gardens Care Center	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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to fulfill a record request for one of one residents (Resident 4), when they had record of a request from 11/5/25 and still had not sent the records as of 12/15/25.This failure put the resident at risk of not receiving his records in a timely manner.During a review of Resident 4'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), dated 10/1/25, the admission record indicated, Resident 4 was admitted to the facility on [DATE] with a diagnosis which included Rhabdomyolysis (a rare muscle injury where your muscles break down. This is a life-threatening condition that can happen after an injury or excessive exercise without rest), muscles weakness and altered mental status (This condition causes changes in consciousness and symptoms that can affect many organ systems). Resident 4 was discharged on 8/27/25 with a length of stay of 28 days.During a concurrent observation and interview on 12/16/25 at 3:45 p.m., with the Medical Records Assistant (MRA) in the medical records office, Resident 4 had a medical records request form from [name of Attorney's Office] on top of the Medical Records Directors (MRD) desk, from 11/5/25 with a blue sticky note on top that read ASAP [as soon as possible] Need within five days! $.10 per page. The MRA stated this was a request for Resident 4 and she had not checked that pile of papers before.During a review of Resident 4's Medical Record Request (MRR) dated 11/5/25, the MRR indicated, .RE [regarding]: [Resident 4], DOB: [DATE]. To Whom it May Concern: [Name of Attorneys Office] respectfully submits this request for production of all your medical and billing records regarding [Resident 4]. All reasonable costs incurred by Oakwood Gardens Care Center in making [Resident 4] records available may be charged to our office. I will have a representative from our office contact you on or about November 7, 2025, to arrange for the production of [Resident 4] records on or before November 14, 2025.During an interview on 12/16/25 at 4 p.m., with the MRA, the MRA stated this was her first week of doing this position on a full-time basis and had only been in this position for a month. The MRA stated she was part-time, working a few days out of the week for the three weeks prior. The MRA stated there was an MRD here at the time of the request, the MRD was hired on 10/30/25 and left on 12/2/25. The MRA stated all record requests went to the MRD during that timeframe. The MRA stated she was unaware of the exact timeframe the request needed to be filled, but this request would need to be filled immediately. The MRA stated the request should have been completed per federal guidelines and it was not.During an interview on 12/19/25 at 2:30 p.m., with the Director of Nursing (DON), the DON stated the expectation for the facility was to fulfill the request but did not have a timeframe to complete the request to her knowledge. The DON stated a potential outcome for Resident 4 would be that he would not receive his records or there would be a significant delay.During an interview on 12/19/25 at 3:45 p.m., with the facility Administrator (ADM), the ADM stated there was not a timeframe to complete a (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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	records request that he knew of. The ADM stated he did not believe there was a federal regulation in regard to a timeframe for a record request as well.During an interview on 12/19/25 at 4 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that a record request should be fulfilled within the federal regulation guidelines. The ADON stated a record request should be completed as soon as possible because the records are important to that person and the facility is there to help them.During a review of the facility's policy and procedure (P&P) titled, Release of Information not dated, the P&P indicated, . Our facility Maintains the confidentiality of each resident's personal and protected health information. The resident may initiate a request to release such information contained in his/her records and charts to anyone he/she wishes. Such requests will be honored only upon the receipt of a written, signed, and dated request from the resident or representative. A resident may have access to his or her records within 48 hours (excluding weekends or holidays) of the resident's written or oral request. Non-personal representatives such as legal firms may have access to his or her records within 30 days of the written request.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) received an accurate fall risk assessment when on admission the licensed vocational nurse supervisor (LVNS) did not accurately account for history of falls at home and hip fracture, mobility deficits in calculating the risk for falls for Resident 1.These failures resulted in assigning a moderate risk rather than a high risk for falls with the potential not to implement an individualized care plan to prevent falls and could have contributed to his fall on 11/15/25.Findings:During a review of Resident 1's skilled nursing facility 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), dated 12/16/25, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with a diagnosis which included an unspecified fracture of unspecified acetabulum (socket in pelvis where hip bone sits), other abnormalities (not normal) of mobility and gait (the way a person walks) and a history of falling.During a review of Resident 1's skilled nursing facility's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], Resident 1's MDS assessment indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) Resident 1's assessment score was 7 out of 15. A score of 7 indicated Resident 1 had a severe cognitive impairment (a person that has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). During a concurrent interview and record review on 12/16/25 at 1:30 p.m. with the Assistant Director of Nursing (ADON), Resident 1's IDT (interdisciplinary team- a group of staff members like nurses, therapists, social workers, dietitians and doctors that meet to make sure the patient's needs are met)- Fall Progress Note (IDT FPN), dated 12/12/25 was reviewed. The IDT FPN indicated, .Fall: 11/15/25.8:50 a.m.The Charge nurse was notified by the nursing staff that the resident was on the floor. resident was identified resting on his left side on the floor with his head facing towards his bed and bilateral (both sides of body) feet slightly positioned under his bed, with bilateral arms at the residence side. The resident was able to move all extremities without any noted pain or discomfort no gross misalignment (not in ideal position) . The resident presents with unpredictableness [sic] and attempts to function beyond ADL limitations. The ADON stated how the actual fall occurred was located in an addendum to this progress note.During a concurrent interview and record review on 12/16/25 at 2:30 p.m. with the ADON, Resident 1's IDT Functional Abilities Collaboration (FAC), dated 11/11/25 to 11/13/25 was reviewed. The FAC indicated Resident 1 was dependent on facility staff to complete all activities of daily living (ADL)that included shower, bathing, hygiene, transfers, bed and chair mobility. The ADON stated that dependent on staff meant Resident 1 could not do any of the ADLs himself physically due to his condition and required two person staff assistance for transfers to and from bed. The ADON stated it appeared only one CNA was assisting him when the resident fell. The ADON stated Resident 1 was assessed with a moderate risk for falls based on his fall risk assessment.During a concurrent interview and record review on 12/19/25 at 2:30 p.m., with the Director of Nursing (DON), Resident 1 fall risk assessment, was reviewed. The DON stated the fall risk assessment was inaccurately scored as the medications that Resident 1 was taking placed him at a higher risk for falls that would have categorized him as a high risk for falls rather than a moderate risk for falls. The DON stated the bed rail question was left unanswered even though Resident 1 had one side rail which also would have adjusted his score. The DON stated the fall risk assessment inaccurately depicted the fall risk (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Resident 1 which could have contributed to potential interventions not being utilized to maintain the safety of the resident.During an interview on 12/19/25 at 4 p.m., with the ADON, the ADON stated information is obtained from the General Acute Care Hospital (GACH) concerning incoming admissions of residents. The ADON stated that information is utilized in the fall risk assessment once the resident has arrived. The ADON stated accurate fall risk assessment are very important because it will identify interventions that should be utilized to treat the residents, maintain safety and falls. The ADON stated if assessment is inaccurate then it can affect not only the fall risk assessment but further assessments such as care plan interventions and monitoring. The ADON stated moderate vs high risk have different interventions that are utilized in order to mitigate risk for falls to the best of our abilities.During an interview on 12/19/25 at 5:10 p.m., with the Director of Nursing (DON), the DON stated the fall risk assessment is the baseline in terms of resident care at the facility. The DON stated the expectation was for this to be completed accurately and it was not. The DON stated a high-risk resident has a high chance to have a fall and a moderate-risk resident had the possibility to have a fall. The DON stated that because the fall risk assessment (completed on 11/11/25) was not accurate for Resident 1, the care plan interventions were not appropriate.During an interview and record review on 12/31/25 at 9:30 a.m., with the LVNS, Resident 1's Fall Risk Assessment (FRA), dated 11/11/25 at 2:40 p.m., was reviewed. The FRA indicated Resident 1 had a score of 14 which would have made him a moderate fall risk. The LVNS stated she was the nurse at admission who completed this FRA. The LVNS stated she completed the FRA inaccurately. The LVNS stated she left a bed rail question incomplete, the medications answer was not correct, and the continent answer was inaccurate. The LVNS stated if she had answered these questions correctly, Resident 1 would have been a high-fall risk based on this assessment, which would have included additional fall interventions.During an interview and record review on 12/31/25 at 10:30 a.m., with the Minimum Data Set (MDS) nurse, Resident 1's MDS Section GG- Functional Abilities, dated 11/14/25 was reviewed. Section GG indicated Resident 1 required complete assistance in attempting all ADL activities and required two or more staff members for transfer assistance.During a concurrent interview and record review on 1/8/26 at 4:19 p.m., with the MDS nurse, Resident 1's fall risk assessment and fall risk care plan was reviewed. The MDS stated Resident 1 baseline fall risk care plan interventions included anticipate and meet needs, keep call light in reach of resident, keep personal items frequently used within reach, keep the environment free from obstruction and clutter, maintain bed in lowest position with brakes locked, monitor for changes in condition affecting risk for falls, orient resident to room, orient resident to call light/restroom/surroundings, and the resident may have a fall mat to left side of bed while in bed, and monitor for side effects of current medication regiment. The MDS stated interventions included in the fall risk care plan were based on the fall risk assessment, diagnosed history and ADL status. The MDS nurse stated care plan interventions included were basic and not individualized to Resident 1's needs. The MDS stated the fall risk assessment for Resident 1 indicated moderate risk for falls which inaccurately depicted the risk Resident 1 had, as he should have been placed under high risk based on his medication regiment, diagnose history, bed rails and safety. The MDS stated based on the inaccuracies of the fall risk assessment, that it also created inaccuracies in the care plan interventions which potentially could have contributed to his fall. The MDS stated, based on the inaccuracy of assessment, the nursing staff could not properly identify the individualized interventions required to prevent future falls and injury while at the facility and could have contributed to his fall with a fracture.During a review of the facility's Licensed Vocational Nurse (LVN) Job description, dated November 2018, the job description indicated, .Chart Nurses' notes in an informative and (continued on next page)

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