

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Oakwood Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 375 Cohasset Rd Chico, CA 95926	

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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>43739</p> <p>Based on interview, and record review, the facility failed to ensure Licensed Nurses (LNs) documented in the electronic medical record for one of six sampled residents (Resident 1) when Resident 1 had a change of condition and was transferred to the acute hospital.</p> <p>These failures resulted in an inaccurate record and had the potential to affect developing an accurate resident plan of care when a change of condition was not documented in the record.</p> <p>Findings:</p> <p>During a review of the facility's policy titled, Change of Condition Notification , revised 4/1/2015, at the section of Documentation , indicated:</p> <p>a. A Licensed Nurse (LN) will document the following:</p> <ul style="list-style-type: none"> - Date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes. - The time the Attending Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received. - The time the family/responsible person was contacted. - The incident and brief details in the 24-Hour Report. - If the resident is transferred to an acute care hospital, complete an inter-facility transfer form. - Complete an incident report per Facility policy. <p>b. A LN will communicate any changes in required interventions to the CNAs involved in the resident's care.</p> <p>c. A LN will document each shift for at least seventy-two (72) hours.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>d. Documentation pertaining to a change in the resident's condition will be maintained in the resident's medical record and on the Twenty-Four-Hour Report</p> <p>During a review of Resident 1's clinical record, indicated that Resident 1 was admitted to the facility originally on 3/7/23 with diagnoses which included chronic kidney disease, diabetes (high blood sugar), and acquired absence of right leg below knee (the right leg below the knee was amputated). Resident 1 was his own healthcare decision maker.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - an assessment and care screening tool), dated 3/14/23, the MDS indicated that Resident1 had a brief interview for mental status (BIMS) score of 12 out of 15, at section C Cognitive Patterns indicating that her cognition (ability to make decisions and memory recall) was mildly impaired.</p> <p>During an interview on 1/7/24 at 11:57 am, with Family A, the Family A stated that she was informed that Resident 1 was transferred to the acute hospital on 5/29/23.</p> <p>During a review of Resident 1's medical record titled, Skilled Nursing Facility (SNF)/Nursing Facility (NF) to Hospital Transfer Form , indicated Resident 1 was transferred to Hospital B on 5/29/23 at 1:35 am, due to Altered Mental Status (a noticeable change in a person's mental function, including their level of consciousness, awareness, cognition, or attention, which can manifest as confusion, disorientation, lethargy, or unusual behavior, often indicating an underlying medical condition requiring prompt evaluation).</p> <p>During a concurrent interview and record review on 1/8/25 at 12:30 pm, with the Director of Staff Development (DSD), Resident 1's medical record was reviewed, the DSD confirmed there was no documentation found in the nursing progress note about Resident 1's change of condition and was subsequent transfer to the acute hospital on 5/29/23. The DSD stated the nurses were required to assess the resident whenever there's a change of condition and document the findings in the resident's record.</p> <p>During a concurrent interview and record review on 1/8/25 at 12:55 pm, with the Medical Record Supervisor (MDS), in the medical record office, Resident 1's medical record was reviewed. The MDS confirmed that Resident 1 was transferred to the hospital due to an altered mental status, based on the information provided on the form titled, Skilled Nursing Facility (SNF)/Nursing Facility (NF) to Hospital Transfer Form , dated 5/29/23. However, the MDS confirmed that she could not find any nursing note in Resident 1's record that was related to this transfer. The MDS stated that the nurses were required to complete the change of condition assessment and document the findings in Resident 1's record when Resident 1 had a change of condition on 5/29/23.</p> <p>During a concurrent interview and record review on 1/8/25 at 2:20 pm, with the Director of Nursing (DON) in the DON's office, the DON confirmed there was no documentation found in the nursing progress note about Resident 1's change of condition and subsequent transfer to the acute hospital on 5/29/23. The DON stated the nursing staff were required to assess the condition of the resident and document the findings in the resident's record whenever there is a change of condition.</p>		