STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055656	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Healthcare Center	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on observation, interview, and record review, the facility failed to ensure a care plan was developed or revised to determine interventions for one of two sampled residents (Resident 1) when Resident 1 expressed he wanted to die. This failure had the potential for Resident 1 to experience a decline in psychosocial and physical wellbeing. Findings: A review of the facility's policy titled Behavior-Threats to Harm Self revised March 2017, indicated the policy's purpose is To respond appropriately to resident who are verbalizing suicidal thoughts and/or comments about self-harm. Resident threats of suicide or self-harm must be reported immediately to the Director of Nurses, Designee and Social Services during regular business hours. The Social Service staff and/or Licensed Nurse will interview the resident to seek additional information regarding an immediate plan or intent to injure him/herself. The residents Care Plan will reflet interventions aimed at decreasing the resident's thoughts of self-harm including, but not limited to: A. Increasing activities of resident's choosing; B Decreasing environmental stimuli; C. Interventions for anxiety or pain; D. More frequent visits by family/surrogate if possible and activity staff; E. More frequent visits by social services for counseling and /or support . A review of Resident 1's Admission Record (undated), indicated Resident 1 was admitted on [DATE] with the diagnoses that included hemiplegia (paralysis) to left side, major depressive (feelings of sadness, and loss of interest) disorder, and dementia (loss of memory, language and problem solving). A review of Resident 1's quarterly Minimum Data Set (MDS, an assessment tool) dated 11/10/24, indicated Resident 1's thinking, decision making, and memory, was severely impaired. Resident 1 was unable to make his own health care decisions. A review of Resident 1's physician orders indicated Resident 1 had an order dated 2/23/24, for sertraline (a medication for depression and anxiety) oral tablet 50 mg (milligrams, a unit of measurement) give 50 mg by mouth one time day for depression for statements of sadness. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's December Medication Administration Record (MAR) indicated that on 12/26/24 during the day shift, Resident 1 had five documented episodes of sadness and depression behaviors. Non pharmaceutical interventions were initiated and documented as helpful. A review of Resident 1's nursing progress notes dated 12/27/24 at 1:23 pm, Licensed Vocational Nurse (LVN) A documented CNA (certified nursing assistant) had stated resident was asking for a doctor to see him, also was informed by CNA of some anxiety noticed by CNA on noc (night) shift. Supervisor alerted to resident and CNA comments. A review of LVN A's communication to Medical Doctor (MD) dated 12/27/24 indicated that LVN A informed MD that Resident 1 was feeling more anxious and wanted to see the doctor. The MD responded with orders to monitor resident. A review of Resident 1's Change in Condition (CIC) SBAR (Situation, Background, Assessment, and Recommendation, a communication tool used in nursing to share information about a resident's condition) dated 12/27/24 at 7:56 pm, LVN B documented Situation: The Change in Condition reported on this CIC evaluation are/were: Falls. Functional Status Evaluation: Fall. Behavioral Status Evaluation: Physical aggression verbal aggression personality change suicide potential. Nursing observations, evaluation and recommendations are: PT (patient/resident) had a skin tear and hematoma (localized collection of blood) caused by fall. PT extremely confused and aggressive, send out to acute to ED (emergency department) department for further evaluation. Primary Care Provider responded with the following feedback: A. Recommendations: Transfer to acute (hospital). A review of a nursing progress note dated 12/28/24 at 0:57 am, LVN B documented, Pt had a witnessed fall on pm shift around 19:45 (7:45 pm). PT became angrier and threw himself to the floor. PT has injuries r/t fall. Hematoma to right forehead and skin tear to right arm. PT was very aggressive toward staff. PT sent to acute, he wouldn't allow staff to assist with injuries or to obtain vitals. (Resident 1's name) expressed wanting to die and wanted to leave home. Pt sent to acute per MD orders for further evaluations and treatment. A review of nursing progress note dated 12/30/24 at 4:16 pm, indicated that Resident 1 was readmitted to the facility. A review of Resident 1's depression care plan dated 1/14/25, indicated interventions to administer medications, arrange for spiritual leader of choice to visit, arrange for psych consult, and assist the resident in developing/provide the resident with a program of activities that are meaningful and of interest. During a concurrent interview with the Unit Manager (UM) and record review on 2/6/25 at 1:40 pm, Resident 1's nursing progress note dated 12/28/24 at 0:57 am was reviewed. UM indicated that she was unaware that Resident 1 had expressed wanting to die. A review of Resident 1's nurses notes, dated 12/30/24 to present, with UM showed that there was no follow up by the facility concerning Resident 1's statement of wanting to die. UM confirmed that there should have been follow-up concerning this statement and there was not. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent interview with the Social Service Director (SSD) and record review on 2/6/25 at 2:10 pm, Resident 1's social service notes and care plans were reviewed. SSD indicated that she was unaware that Resident 1 had stated he wanted to die. SSD indicated that if she would have known this then she would have followed thru with her protocol to make sure Resident 1 was safe in his room. SSD indicated that she should have monitored Resident 1 daily for 72 hours for psychosocial wellbeing. SSD indicated that there were no notes concerning monitoring for wanting to die and there should have been. SSD reviewed Resident 1's care plan and confirmed that there were no interventions added to a care plan for the statement of wanting to die and there should have been to ensure his safety.