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	05/01/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on interview and record review, the facility failed to protect one of four sampled residents (Resident 2) from verbal abuse when Resident 1 made derogatory comments and yelled profanities directed at Resident 2 while in the hallway. This failure had the potential to negatively affect the psychosocial and mental health for Resident 2 and other residents within hearing range. Findings: A review of the facilities policy titled, Abuse Prevention and Management revised 5/30/24, indicated, Verbal abuse is defined as any use of oral, written, gestured communication, or sounds that willfully include disparaging (to belittle the value or importance of someone) and derogatory (showing a disrespectful attitude) terms directed to residents within their hearing distance. A review of the facilities document titled, Resident [NAME] of Rights dated 5/11, the policy indicated patients shall have the right to be free from mental and physical abuse. A review of Resident 1's admission record showed he was initially admitted to the facility on [DATE] with diagnoses that included osteomyelitis of vertebra (a bone infection of the spine), end stage renal disease (kidney disease), diabetes (high sugars in the blood), heart failure, and paraplegia (weakness or paralysis in both legs). Resident 1 was capable of making his own healthcare decisions. A review of Resident 2's admission record showed she was initially admitted on [DATE] with diagnoses that included heart failure, kidney disease, chronic pain syndrome, depressive disorder, bipolar disorder (a mental illness characterized by extreme and persistent shifts in mood, energy and activity levels), and an anxiety disorder. Resident 2 was capable of making her own healthcare decisions. During a review of Resident 1's Behavior Note dated 3/23/25 at 8:27 am, Licensed Nurse (LN) A documented, [Resident 1] observed at nurse's station this morning more than 15 min [minutes] till smoke break screaming and cursing at another resident [Resident 2] in hallway to move her chair. After the resident [Resident 2] that was being verbally assaulted said, ' Please wait I'm trying to move' and asked the resident [Resident 1] could he please not talk to her in such a way. This resident [Resident 1] became angrier and continued using profanity in an inappropriate way toward her. (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

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	05/01/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Behavior Note dated 3/25/25 at 10:45 am, the Administrator (Admin) documented, Met with resident [Resident 1] to discuss incident of this weekend when he started yelling and cussing at a female resident [Resident 2] who was in the hallway, he told her to move, and she told him to give me a minute- when he started yelling in a loud voice and calling her a F . Bitch. During an interview on 4/22/25 at 9:50 am, Resident 2 stated Resident 1, Hurts my feelings. He screams and yells at everyone. I was in the hall, and he was just coming out of his room, and he yelled at me to get the hell out of my hallway. No one did anything, he gets away with everything. During an interview on 4/22/25 at 3:51 pm, LN B indicated that she observed Resident 1's verbal altercation with Resident 2, LN B stated, He [Resident 1] was coming down the hall for a smoke break, [Resident 2] was sitting in the way and he said get the F . out of the way. During an interview on 4/29/25 at 3:26 pm, LN A stated, [Resident 1] had come out of his room in a hurry so he would not miss his smoke break. [Resident 2] was sitting at the nursing station area where all the residents congregate after breakfast. [Resident 2] was in [Resident 1's] way and [Resident 1] went into calling [Resident 2] names and using foul language. He was so angry about [Resident 2] he just kept rolling out to the dining room fast and to the smoking area. He kept yelling profanities all the way out the door. During an interview with the Admin on 4/24/25 at 12:33 pm, the Admin indicated they have been working with Resident 1 about his behavior and have written up behavior expectations to help Resident 1 manage his outbursts.

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	05/01/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43755 Based on interview and record review, the facility failed to report an abuse allegation for one of four sampled residents (Resident 2), to the California Department of Public Health (CDPH), Ombudsman (Resident advocate organization), and local law enforcement, within two-hours after Resident 1 made derogatory comments and yelled profanities directed at Resident 2 while in the hallway. This had the potential for Resident 2, and other residents, to be vulnerable and unprotected from mistreatment, and negatively impact their emotional and psychosocial well-being. Findings: On 4/22/25 at 9:00 am, an onsite visit was made to the facility to investigate a self-reported abuse allegation which had occurred on 3/23/25. The self-reported abuse document titled, Intake Information dated 3/26/24, indicated Nursing Supervisor (NS) reported the abuse allegation to CDPH, Ombudsman, and local law enforcement on 3/26/25, three days after the event, that Resident 1 was being verbally aggressive to Resident 2, because she wasn't able to move out of his way quick enough. Resident 1 became angrier and continued to yell profanities at Resident 2 and Resident 1 was yelling at the top of his lungs. A review of the facility policy titled, Abuse Prevention and Management revised 5/30/24, indicated, 7.a. The administrator or designated representative will notify law enforcement, by telephone immediately, or as soon as practicable possible, but no longer than two hours of an initial report and send a written SOC341 (a mandated reporting form used in California to report suspected abuse, neglect, or financial exploitation of elders or dependent adults) report to the Ombudsman, law Enforcement, and CDPH Licensing and Certification within two hours. During an interview on 4/24/25 at 3:50 pm, the Director of Nursing (DON) confirmed that the SOC341 for the abuse allegation that occurred on 3/23/25, was filled out and sent in on 3/26/25, three days after the allegation, and it should have been done within 2 hours.

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	05/01/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) had a care plan developed to address Resident 1's use of Methamphetamine (illegal drug in the form of [NAME] Meth and is highly addictive and causes feelings of euphoria and increased alertness and energy and can cause violence, paranoia, anxiety, rapid heart rate, irregular heartbeat, stroke, or even death). This deficient practice had the potential to result in a decline in Resident 1's health status related to the lack of interventions and monitoring for signs and symptoms of substance abuse which could result in a potential overdose. Findings: A review of the facility's policy titled, Comprehensive Person-Centered Care Planning revised November 2018, indicated, It is the policy of this Facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being. A review of Resident 1's admission record showed he was initially admitted to the facility on [DATE] with diagnoses that included osteomyelitis of vertebra (a bone infection of the spine), end stage renal disease (kidney disease), diabetes (high sugars in the blood), heart failure, and paraplegia (weakness or paralysis in both legs). Resident 1 was capable of making his own healthcare decisions. A review of Resident 1's History and Physcial dated 3/12/21, showed that the facility's Medical Director (MD) documented that Resident 1 had a history of, Meth Abuse. A review of Resident 1's Behavior Contract by Administrator (Admin) dated 10/21/24, indicated .CNA [Certified Nursing Assistant] saw a clear Ziploc type baggie containing what was described as white crystalized small size broken up rock substances under his [Resident 1's] pillow. Officer [name] of the Police Department . identified the contents as [NAME] Meth. A review of Resident 1's drug screen test, date collected 10/18/24 and date reported 10/29/24, indicated Resident 1 tested positive for Methamphetamine. During a concurrent interview and record review with Minimum Data Set Nurse (MDS) on 5/1/25 at 1:29 pm, Resident 1's care plan's were reviewed. MDS confirmed Resident 1 did not have a care plan developed with interventions to manage Resident 1's use of illegal drugs. During a concurrent interview and record review with the Director of Nursing (DON) on 5/1/25 at 4:36 pm, Resident 1's care plans were reviewed. The DON confirmed that there was no care plan developed for Resident 1's illegal drug use and there should have been.

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	05/01/2025

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 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** 43755 Based on interview and record review, the facility failed to ensure that one of four sampled residents (Resident 1) who had a known Substance Abuse Disorder (SUD, an individual who uses and/or abuses illegal drugs and/or alcohol), was provided with the necessary monitoring and supervision to prevent avoidable accidents and hazards when: 1. Resident 1 frequently went out of the facility on pass and was not evaluated or assessed for signs of drug use and/or overdose upon his return to the facility. 2. Nursing staff had not received training or education on how to manage potential emergencies that could arise for residents with a SUD. (Refer to F741) 3. The facility failed to develop a SUD plan of care for Resident 1 with goals and interventions to mitigate potential accidents, hazards, and drug overdose. (Refer to F656) These failures had the potential for changes in Resident 1's condition to go unrecognized and nursing staff that were not prepared to address emergencies related to Resident 1's SUD, which could result in negative clinical outcomes and harm for Resident 1. Findings: A review of the facility's policy titled, Resident Safety revised 4/15/21, indicated, To provide a safe and hazard free environment. During the comprehensive assessment period the interdisciplinary team (IDT) members will assess the Resident's safety risk .as well as any other Resident specific safety risks. Residents will be evaluated on admission, quarterly and whenever there is a change in condition to identify circumstances that pose a risk for the safety and wellbeing of the Resident. II. During the quarterly care plan review, when there is a change in condition or if an accident or incident occurs that involves the Resident's safety, the Resident's safety risk will be reevaluated. After a risk evaluation is completed, a Resident-centered care plan will be developed to mitigate safety risks factors. 1. A review of Resident 1's admission record showed he was initially admitted to the facility on [DATE] with diagnoses that included osteomyelitis of vertebra (a bone infection of the spine), end stage renal disease (kidney disease), diabetes (high sugars in the blood), heart failure, and paraplegia (weakness or paralysis in both legs), dialysis (artificial means of cleansing the bloodstream when kidneys can no longer filter the blood), and a dialysis shunt (where a vein and artery are surgically connected for direct permanent access to the bloodstream). Resident 1 was capable of making his own healthcare decisions. A review of Resident 1's History and Physical (H&P) dated 3/12/21, reflected the facility's Medical Director (MD) documented that Resident 1's had a history of Meth Abuse [Methamphetamines, illegal drug in the form of [NAME] Meth and is highly addictive and causes feelings of euphoria and increased alertness and energy and can cause violence, paranoia, anxiety, rapid heart rate, irregular heartbeat, stroke, or even death]. (continued on next page)

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	05/01/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Behavior Contract by Administrator (Admin) dated 10/21/24, indicated .CNA [Certified Nursing Assistant] saw a clear Ziploc type baggie containing what was described as white crystalized small size broken up rock substances under his [Resident 1's] pillow. Officer [name] of the [name] Police Department . identified the contents as [NAME] Meth. A review of Resident 1's drug screen test, that was required and requested by the Police Department, date collected 10/18/24 and date reported 10/29/24, indicated Resident 1 tested positive for Methamphetamine. A review of Resident 1's Physician's Order Summary Report, dated 2/24/25, reflected that Resident 1 had a physician's order, Standing order resident [Resident 1] allowed to sign self OOF [out of facility] daily must return to facility before midnight. During an interview with Licensed Nurse (LN) B on 4/24/25 at 8:45 am, LN B indicated that Resident 1 often leaves the facility and stays out until midnight. During an interview with LN A on 4/29/25 at 3:26 pm, LN A stated, He [Resident 1] has incidences where he goes out of the facility. A review of facility's, Resident Sign In/Sign Out document, dated from 4/8/25 thru 4/24/25, showed that Resident 1 had signed himself out of the facility on 4/8/25 at 5:30 pm, and on 4/19/25 at 2:45 pm. There was no documentation of when Resident 1 returned to the facility or his condition upon his return. During a concurrent interview and record review with the Front Desk Attendant (FDA) on 5/1/25 at 1:07 pm, the facility's, Resident Sign In/Sign Out document dated 4/8/25 thru 4/24/25 was reviewed. FDA confirmed that Resident 1 had signed himself out of the facility on 4/8/25 and 4/19/25, but did not sign back in when he returned to the facility. FDA indicated that Resident 1 goes out a couple times a week but does not always sign out or back in. A review of Resident 1's Nursing Progress notes, dated 4/8/25 and 4/19/25, had no documentation that Resident 1 had signed himself out of the facility or when he returned. During an interview with LN E on 5/1/25 at 4:09 pm, LN E indicated that Resident 1 was allowed to leave the facility on his own and comes back later at random times. LN E indicated that staff should be monitoring his condition upon return for drug use but was not sure if they were. During a concurrent interview and record review with the Director of Nursing (DON) on 5/1/25 at 4:36 pm, Resident 1's 4/8/25 and 4/19/25 Nursing Progress notes were reviewed. DON confirmed that nurses had not documented when Resident 1 left the facility or when he returned and his condition upon return, and there should have been. DON indicated that Resident 1 should be monitored and assessed for drug overuse when he returns to the facility from his leave of absence, and the facility had not been doing this. (continued on next page)

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	05/01/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview on 4/22/25 at 10:53 am, Restorative Nursing Assistant (RNA, a certified nursing assistant who works with residents to restore strength) indicated Resident 1 had episodes of aggression, throws food, yells and swears at residents and staff. RNA indicated she had not had training for behavioral management of residents with SUD or signs and symptoms of being under the influence of drugs. During a concurrent interview and record review with the Director of Staff Development (DSD) on 4/22/25 at 12:26 pm, April 2024 to April 2025 staff training records were reviewed. DSD confirmed there had not been any staff training on SUD. During an interview on 4/22/25 at 2:11 pm, Social Service Director (SSD) confirmed that [NAME] Meth had been found in Resident 1's room on 10/18/24, and that she was aware that Resident 1 had a past history of drug abuse. SSD indicated she had not received training on SUD. During an interview on 4/24/25 at 8:45 am, LN B indicated that it would be helpful to have training concerning SUD and to know how to deal with Resident 1's behavior outbursts and potentials for an overdose. LN B confirmed training on the management of a resident with SUD had not happened. During an interview on 4/29/25 at 3:26 pm, LN A confirmed she has not had training for the management of a resident with SUD. During an interview on 4/24/25 at 12:33 pm, the Director of Nursing (DON) indicated that Resident 1 was found to have illegal drugs in his possession and tested positive for drugs back in October 2024. DON confirmed that Resident 1 had numerous physical and verbal altercations with other residents and staff and had had frequent outbursts of anger and using inappropriate language around facility. DON indicated the facility had not done training on SUD, but should have. 3. During a concurrent interview and record review with Minimum Data Set Nurse (MDS) on 5/1/25 at 1:29 pm, Resident 1's Care Plans were reviewed. MDS confirmed Resident 1 did not have a care plan developed with interventions to manage Resident 1's SUD and one should have been developed.

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	05/01/2025

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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on observation, interview and record review, the facility failed to ensure that staff were trained and competent to care for one of one sampled resident (Resident 1) who had a Substance Use Disorder (SUD, an individual who uses and/or abuses illegal drugs and alcohol) when Resident 1 had many numerous physical and verbal altercations with other residents and staff over the past year, and staff indicated they did not know how to deal with these behaviors of someone with a SUD and indicated they had not received training on it. This failure has the potential for Resident 1 not to receive care and services to safely manage his SUD and result in a decline in his physical, emotional and psychosocial well-being and put other residents' health, safety and welfare at risk. Findings: A review of the, Facility Assessment (an assessment to determine what resources are necessary to care for its residents competently during both day-to day operations [including nights and weekends] and emergencies) dated 12/6/24, indicated the facility assessment identified serving a population of residents with, Active or current substance use disorders. The Facility assessment indicated that the assessment will be used to, Inform staffing decisions to ensure that there are a sufficient number of staff with appropriate competencies and skill sets necessary to care for the residents' needs as identified through the resident assessment and plan of care. A review of Resident 1's Admission record showed he was initially admitted to the facility on [DATE] with diagnoses that included osteomyelitis of vertebra (a bone infection of the spine), end stage renal disease (kidney disease), diabetes (high sugars in the blood), heart failure, and paraplegia (weakness or paralysis in both legs). Resident 1 was capable of making his own healthcare decisions. There was no documentation on Resident 1's Admission record that he had a history of substance abuse. A review of Resident 1's, General History and Physical (H&P) note, dated 2/5/21, the acute hospital Physician (PHY) indicated Resident 1 had a history of methamphetamine abuse (illegal drug in the form of [NAME] Meth and is highly addictive and causes feelings of euphoria and increased alertness and energy. Some side effects from using crystal meth include violence, anxiety, and skin sores). During an interview on 4/22/25 at 10:53 am, Restorative Nursing Assistant (RNA, a certified nursing assistant who works with residents to restore strength) indicated Resident 1 had episodes of aggression, throws food, yells and swears at residents and staff. RNA indicated she had not had training for residents with SUD. During a concurrent interview and record review with the Director of Staff Development (DSD) on 4/22/25 at 12:26 pm, the DSD confirmed that the facility had never conducted any trainings to staff about SUD. After a review of all of the trainings that had been provided to staff, the DSD could only show evidence of Dementia trainings from 12/31/24 to 1/3/25. (continued on next page)

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	05/01/2025

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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/25 at 2:11 pm, Social Service Director (SSD) indicated that Resident 1 had behavior outbursts with yelling, screaming and using profanity toward staff and residents. SSD indicated she had offered to schedule psychiatric services for Resident 1 but that he had refused in the past. SSD indicated that [NAME] Meth had been found in Resident 1's room on 10/18/24, and he had a past history with drug abuse. SSD indicated she had not had training on SUD or what to look for concerning illegal drugs. During an observation and interview on 4/22/25 at 3:19 pm, Resident 1 was observed sitting in his wheelchair in his private room. Resident 1 stated, I have anger issues. I am set in my ways and when they cannot get it right repeatedly, I tend to get upset. During an interview on 4/24/25 at 8:45 am, Licensed Nurse (LN) B indicated that it would be helpful to have training concerning SUD and to know how to deal with Resident 1's behavior outbursts. LN B continued to say that training on the management of a resident with SUD had not happened. During an interview with the Medical Director (MD) on 4/24/25 at 2:27 pm, MD confirmed that Resident 1 had a SUD, and his admission record should have been updated to include a diagnosis of SUD and it was missed. During an interview on 4/29/25 at 3:26 pm, LN A indicated that Resident 1 was verbally abusive to residents. LN A stated, I do not know what to do or where to go. I am not trained with behavioral issues such as this. He snaps and the verbal and mental abuse is so profound. We do not know what to do it is so scary. LN A indicated she has not had training for the management of a resident with SUD. During an interview on 4/24/25 at 12:33 pm, the Director of Nursing (DON) confirmed that Resident 1 was found to have illegal drugs in his possession and tested positive for drugs back in October 2024. DON confirmed that the Resident 1 had numerous physical and verbal altercations with other residents and staff and had had frequent outbursts of anger, using inappropriate language in and around facility. DON indicated the facility had not done training on SUD but should have.