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	07/02/2025

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** Based on interview and record review, the facility failed to follow their Fall Management Program policy and procedure (P&P) for one out of three residents sampled for falls (Resident 1). Specifically, the facility staff initiated the required post-fall documentation on 5/19/25, two days after Resident 1 fell, instead of initiating a Post-Fall Huddle (includes updating the care plan, interviewing witnesses and documentation in the medical record), within 15-20 minutes after Resident 1's fall on 5/17/25. This failure caused a delay in the facility-initiated fall investigation to be completed, had the potential to cause a delay in care, and placed Resident 1 at an increased risk for more falls. Findings: A review of the facility's P&P titled, Fall Management Program, revised 3/13/21, indicated, after a resident had a fall, the Licensed Nurse (LN) would perform a post-fall evaluation (assessments and documentation that were required to be completed) after a resident fell. The P&P indicated, the Physician, Director of Nursing (DON), and the residents responsible party (RP, decision maker) would be notified after a resident fell. The P&P indicated, Within 15-20 minutes after a fall, the licensed nurse will initiate a Post-Fall Huddle . that included witnesses who were able to provide additional information regarding the fall. The P&P indicated, after the post-fall huddle was completed, the LN would immediately update the care plan (a document that described resident goals that included the support and care that was required from staff to achieve their goals). The P&P indicated, after a fall, LN would complete an Incident and Accident Report that included interviewing anyone who witnessed the fall. The P&P indicated, the LN would document in the medical record the date and time the fall occurred, a description of the incident, an assessment of the resident that included resident condition after the fall occurred, and who was notified of the fall. A review of the admission Record, dated 7/2/20, indicated Resident 1 was admitted to the facility on [DATE] with the diagnoses of dementia (a general term for a group of brain disorders that caused memory loss and the ability to think, or problem solve). The admission Record, indicated, on 5/25/25, Resident 1 was diagnosed with a displaced midcervical fracture of right femur, subsequent encounter for closed fracture with routine healing (a right hip fracture that required surgery). Resident 1 was not his own RP. A review of Resident 1's care plan, titled actual witnessed fall, dated 5/20/25, indicated Resident 1 had a witnessed fall on 5/17/25 at 10:00 pm. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(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	During a concurrent interview and record review on 7/2/25, at 12:45 pm, with LN A, Resident 1's progress notes and LN assessments, dated 5/17/25 through 5/20/25 were reviewed. LN A stated, when a resident had a fall, the role and responsibility of the LN included assessing and observing the resident for injuries, contacting the Physician, DON, and RP, and documenting the fall. LN A stated, documentation included, completing a risk management form, describing the fall, the actions taken by the nurse, a head-to-toe assessment, and interviewing the residents and witnesses. We also document a change of condition, update the care plan, and create an actual fall care plan (an actual fall care plan described what happened and new care instructions). LN A reviewed the Change of Condition Follow-Up Note, dated 5/19/25, and confirmed, the Change of Condition Follow-Up Note, indicated, Resident 1 had a fall on the evening of 5/17/25. LN A confirmed, prior to 5/19/25, there was no documentation in Resident 1's medical record that indicated he had sustained a fall. LN A confirmed that the actual fall care plan was not initiated until 5/20/25. During a concurrent interview and record review on 7/2/25 at 12:59 pm, Resident 1's progress notes and LN assessments, dated 5/17/25 through 5/20/25 were reviewed. DON stated, LN expectancy after a resident fall was to follow the facility's fall policies and procedures. DON confirmed, LN were to perform a post-fall evaluation and notify the Physician, DON, and the residents RP. DON confirmed, LN were expected to initiate a post-fall huddle and complete the Incident and Accident Report. DON confirmed, LNs were expected to document a description of the fall, an assessment of the resident, that included resident condition after the fall occurred, and who was notified of the fall. DON stated, the resident is placed on alert charting [a special alert note that was entered into the medical record by the LN on each shift, that included information regarding what happened, what the resident was being monitored for, and if the resident had any side effects or complications] for 72-hours and LN would complete change of condition documentation. DON stated, I discovered what had happened on Monday, 5/19/25 and confirmed, LN C had not performed any required documentation and did not report to anyone that Resident 1 had fallen on 5/17/25 at 10:00 pm. During an interview on 7/2/25 at 2:35 pm, the facility's Administrator confirmed, Resident 1 had a fall on 5/17/25 at 10:00 pm and LN C had not reported or documented the fall. During an interview on 7/2/25 at 3:32 pm, LN C confirmed that Resident 1 had a fall on 5/17/25. LN C could not recall the time he was notified of the fall and confirmed his shifted ended at 10:30 pm. LN C stated, I was in the middle of narc count (during shift change, the nurse ending their shift and the nurse beginning their shift counted all narcotic medication to ensure none were missing) and we were notified Resident 1 fell. I performed an assessment on Resident 1 and did not document it. LN C stated, the oncoming nurse performed a head-to-toe assessment, I was on my way out the door when the fall occurred, and the oncoming nurse said she would handle it. During an interview on 7/2/25 at 4:26 pm, LN C confirmed, on 5/17/25 he was Resident 1's LN on the night shift and stated, the shift started at 10:30 pm. LN C stated, no one interrupted the narc count to say Resident 1 fell. I was not aware that Resident 1 had fallen until a few days later. LN C verbalized the facility's P&P regarding resident falls and stated, if I was notified that Resident 1 fell, I would have assessed him to ensure that he was okay.