

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 11/06/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop a care plan (a written plan that outlined how the facility and staff would meet the resident needs) for four out of five sampled residents (Residents 2, 3, 4, and 5) when there was no care plan present that described the use of a mechanical lift (medical device on wheels that was used to transfer residents who could not bear their own weight). This had the potential for residents not to obtain or maintain their highest practical physical, mental, and psychosocial well-being and lead to potential accidents from not being transferred properly. Findings: A review of the facility's policy and procedure titled, Comprehensive Person-Centered Care Planning, dated 9/7/23, indicated a care plan would be developed for each resident that included standards for meeting safety and health care needs. A review of Resident 2's admission Record, dated 7/18/24, indicated, Resident 2 was admitted to the facility on [DATE] with the diagnosis of quadriplegia (unable to move arms and legs on their own). Resident 2 was their own responsible party (RP, decision maker). A review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 10/25/25, indicated that Resident 2 was dependent (required maximum assistant could not do on own) upon facility staff for showers, using the bathroom, and to transfer out of bed into a chair. A review of Resident 2's Lift/Transfer Evaluation, dated 11/4/25, indicated Resident 2 could not bear any weight (support weight while standing). A review of Resident 3's admission Record, dated 1/14/16, indicated, Resident 3 was admitted to the facility on [DATE] with the diagnoses of dementia (severe memory loss) and muscle weakness. Resident 3 was not their own RP. A review of Resident 3's MDS, dated [DATE], indicated Resident 3 was dependent upon staff for showers and transfers out of bed into a chair. A review of Resident 3's Lift/Transfer Evaluation, dated 8/5/25, indicated Resident 3 could not bear any weight. A review of Resident 4's admission Record, dated 8/12/20, indicated, Resident 4 was admitted to the facility on [DATE] with the diagnoses of dementia and muscle weakness. Resident 4 was not their own RP. A review of Resident 4's MDS, dated [DATE], indicated Resident 4 was dependent upon staff for showers and transfers out of bed into a chair. A review of Resident 4's Lift/Transfer Evaluation, dated 10/21/25, indicated Resident 4 could not bear any weight. A review of Resident 5's admission Record, dated 9/6/24, indicated, Resident 5 was admitted to the facility on [DATE] with the diagnosis of adult failure to thrive (a gradual decline in health that had no explanation). Resident 5 was not their own RP. A review of Resident 5's MDS, dated [DATE], indicated Resident 5 was dependent upon staff for showers and transfers out of bed into a chair. A review of Resident 5's Lift/Transfer Evaluation, dated 10/11/25, indicated Resident 5 could not bear any weight. During a concurrent record review and interview on 11/5/25 at 4:15 pm, with Administrator (Admin), Residents 2, 3, 4, and 5's Care Plans were reviewed. Admin stated, There should be a care plan for [residents that use] a mechanical lift. Admin reviewed each resident's active care plan and the discontinued care plans and confirmed, there was no care plan present that indicated Residents 2, 3, 4, and 5 required the use of a mechanical lift for transfer.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055656
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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed prevent an avoidable fall with injuries when staff had not correctly used a Hoyer lift (a mechanical device with a sling that has straps which are to be securely attached to the device used to lift and carry a resident to a desired location. This lift requires two staff for a safe transfer, one to operate the lift and one to guide the resident), for one of five sampled residents (Resident 1) when: 1a. Staff had not ensured the straps on the Hoyer lift were secure and the sling straps came off and dropped Resident 1 onto the floor. 1b. While one staff operated the Hoyer lift, the second staff had not stood by and guided Resident 1 during the transfer. 1c. Staff placed Resident 1 in a Hoyer sling that had damaged straps which were rigid and stiff and should not have been used. 1d. Staff placed Resident 1 in a Hoyer sling that was not previously identified to be the correct size for her. The cumulative effects of these failures caused Resident 1 to fall out of the Hoyer lift on to the metal leg of the lift and onto the floor. Resident 1 sustained four broken bones in her lower back and pelvis (the large bony structure near the base of the spine), severe back pain with an increased need for narcotic pain medication, the need for supplemental oxygen use (extra air breathed in by a tube in the nose), and a hospital stay. Findings: 1a. A review of the facility's policy and procedure (P&P) titled, Fall Management Program, revised 3/13/21, indicated, the purpose of the P&P was to provide residents a safe environment that minimizes complications associated with falls. A review of the admission Record, dated 8/15/20, indicated, Resident 1 was admitted to the facility on [DATE] with the diagnoses of fusion of spine, cervical region (a surgical procedure where two bones in the neck are joined together to stop them from moving) and low back pain. A review of the Physician's Order, dated 8/25/23, indicated, Resident 1 could make their own decisions. A review of the Minimum Data Set (MDS, a resident assessment tool), dated 8/21/25, indicated a Brief Interview of Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was performed. Resident 1 scored 15 out of 15 which indicated good memory. The MDS indicated Resident 1 had limited movement of both legs, and Resident 1 was dependent on two facility staff for transfers from the bed to the wheelchair, bathroom, and shower. A review of the, Post Fall Evaluation, dated 10/29/25, written by Licensed Nurse (LN) A indicated, Certified Nurse Assistant (CNA) B and Nurse Assistant (NA, an uncertified nurse assistant who is still in training) D attempted to transfer Resident 1 from the bed to the wheelchair and witnessed both lower sling straps (closer to the legs) dislodge from the mechanical lift. Resident 1 fell to the floor next to the bed and landed on her back. A review of the hospital's, History and Physical, dated 10/29/25, indicated, Resident 1 was brought into the emergency room by ambulance due to a three-to-four feet fall from a mechanical lift, landing on her backside. A review of the medical imaging report done at the hospital titled, CT [rotating x-ray machine] Abdomen [belly area] Pelvis [hip area] dated 10/29/25, indicated, Resident 1 had acute (sudden) fractures of the right sacrum (bone that connects the spine to the pelvis), right L5 transverse process fracture (last bone in the spine, just above the sacrum), right inferior pubic ramus fracture (a bone that points down from the pelvis), and a fractured coccyx (tailbone). During a concurrent observation and interview on 10/31/25 at 9:43 am, Resident 1 was observed in bed, lying on her back, and wearing a nasal cannula (oxygen tube that fits into the nose). Resident 1 confirmed falling from the mechanical lift on 10/29/25 and stated, I was getting up into the wheelchair and the sling gave way. It looked like the sling detached from the Hoyer [the brand name of the mechanical lift that was used]. I don't feel like I slipped out, I fell straight down. During the interview, Resident 1 appeared to become short of breath while talking and paused in between sentences. Resident 1 confirmed, CNA B and NA D transferred her using the Hoyer lift when she fell and stated, [CNA B] and [NA D] got me into the Hoyer. Resident 1 became tearful and stated, I can't lift my body more than two inches off the bed. The pain is excruciating and sharp. Resident 1 described excruciating pain as a ten-out-of-ten, where ten was the worst pain ever. Resident 1 attempted to raise the upper half of her body off the bed, cried out in pain, and stated, see, I can't do anything. Resident 1 stated, I'm upset because I was able to leave weekly to visit my husband and now I can't go anywhere. It's the holidays, I can't go home to visit or celebrate the holidays. Resident 1 became teary eyed and stated, I have to cancel my mammogram [test to detect early warning signs of breast cancer], my DMV [Department of Motor Vehicles] appointment, all my appointments are cancelled. During an interview on 10/31/25 at 11:47 am, CNA B confirmed assisting with a transfer, utilizing the Hoyer lift. CNA B stated, I saw her fall, she just went straight down, she didn't slip out of the sling, she fell</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>(continued on next page)</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their Resident Safety and Maintenance Service policies and procedures (P&P) when: 1. Facility staff knew the mechanical lift (device on wheels used to transfer residents that could not walk) was broken, did not report it, and used it to transfer four out of five sampled residents (Residents 2, 3, 4, and 5); and 2. The Maintenance Department failed to ensure the broken mechanical lift was removed from use, reported as broken, and did not consistently perform monthly routine maintenance of all mechanical lifts that were utilized in the facility. This had the potential to cause an accident and injuries from using broken equipment to lift and transfer all residents who required the use of a mechanical lift and negatively impact their physical and emotional well-being. Findings: 1. A review of the facility's P&P titled, Resident Safety, revised 4/15/21, indicated, any facility staff that identified an unsafe situation, should immediately notify their supervisor or the charge nurse. A review of the admission Record, dated 7/18/24, indicated, Resident 2 was admitted to the facility on [DATE] with the diagnosis of quadriplegia (unable to move arms and legs on their own). Resident 2 was their own responsible party (RP, decision maker). A review of the Minimum Data Set (MDS, a resident assessment tool), dated 10/25/25, indicated a Brief Interview of Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was performed. Resident 2 scored 14 out of 15 which indicated good memory. The MDS indicated Resident 2 was dependent upon facility staff for showers, using the bathroom, and to transfer out of bed into a chair. A review of Resident 2's Lift/Transfer Evaluation, dated 11/4/25, indicated Resident 2 could not bear any weight (support weight while standing). A review of the admission Record, dated 1/14/16, indicated, Resident 3 was admitted to the facility on [DATE] with the diagnoses of dementia (severe memory loss) and muscle weakness. Resident 3 was not their own RP. A review of the MDS, dated [DATE], indicated Resident 3 was dependent upon staff for showers and transfers out of bed into a chair. A review of Resident 3's Lift/Transfer Evaluation, dated 8/5/25, indicated Resident 3 could not bear any weight. A review of the admission Record, dated 8/12/20, indicated, Resident 4 was admitted to the facility on [DATE] with the diagnoses of dementia and muscle weakness. Resident 4 was not their own RP. A review of the MDS, dated [DATE], indicated Resident 4 was dependent upon staff for showers and transfers out of bed into a chair. A review of Resident 4's Lift/Transfer Evaluation, dated 10/21/25, indicated Resident 4 could not bear any weight. A review of the admission Record, dated 9/6/24, indicated, Resident 5 was admitted to the facility on [DATE] with the diagnosis of adult failure to thrive (a gradual decline in health that had no explanation). Resident 5 was not their own RP. A review of the MDS, dated [DATE], indicated Resident 5 was dependent upon staff for showers and transfers out of bed into a chair. A review of Resident 5's Lift/Transfer Evaluation, dated 10/11/25, indicated Resident 5 could not bear any weight. During an interview on 11/4/25 at 11:28 am, Maintenance Supervisor (MS) confirmed, when a mechanical lift was broken, it was labeled as broken, and removed from use. During a concurrent observation and interview on 11/5/25, with Certified Nurse Assistant (CNA) B the only mechanical lift that was available for use, located on Station 2 was observed. There were two legs (the base of the mechanical lift that was on wheels) that opened and closed on its own while pushing the mechanical lift forward, and the handle (used to open and close the legs) lifted out and detached from the mechanical lift. CNA B stated, the handle for opening the legs, slides on its own, and comes off. CNA B confirmed that the broken mechanical lift was not reported to anyone today. During an interview on 11/5/25 at 12:35 pm, Central Supply/CNA F confirmed the handle to the mechanical lift came off and stated, They always have to tighten it up. It was just serviced to. During a concurrent observation and interview on 11/5/25 at 12:38 pm, CNA G stated, I have been here since 2021, sometimes when you push or turn the mechanical lift, the legs open. CNA G was in the process of taking the broken mechanical lift into Resident 2's room when MS arrived. MS confirmed having knowledge that the mechanical lift's handle came off and stated, I tighten the bottom, not the handle. CNA G stated, I've been here for four years, it has been reported multiple times. MS stated, If they don't add it to the maintenance log, then it's word of mouth (verbally telling MS something was broken and not writing it down). The handle was removed from the base of the mechanical lift, and the bottom of the handle was covered in black tape. MS walked away and did not remove the broken mechanical lift from service. During a concurrent observation and interview on 11/5/25 at 12:48 pm, CNA B and CNA G were observed taking the broken mechanical lift to Resident 2's room. CNA B asked the surveyor, Can we use the mechanical lift?</p>		