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 03/26/2026
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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who entered the facility without pressure injuries (PIs, bed sores) did not develop PIs, develop care plans related to the PIs, identify heel PIs, and manage PIs in one of three residents sampled for PIs (Resident 1) when:1. Facility nursing staff failed to recognize a PI on Resident 1's coccyx (the small, triangular bone at the very bottom of the spine) until it was a stage 2 PI (partial-thickness skin loss with exposed dermis [the middle layer of the skin]).2. A specialized mattress was not obtained for Resident 1 until 11 days after her coccyx PI was discovered.3. Facility nursing staff failed to recognize the development of PIs on Resident 1's heels until her family told staff that Resident 1's heels were hurting.4. No change in condition assessment (documentation completed in a patient's chart after an unexpected change in the patient's physical or mental state occurs, documentation includes specific observations, the assessments of the patient performed, and any actions taken, completed to ensure a clear record for communication and follow-up) was completed for Resident 1's coccyx PI.5. No care plan (a document that outlines a patient's health care needs and the actions and interventions required to address them) was developed for Resident 1's coccyx PI until 8 days after it was discovered.6. The Registered Dietitian (RD is a food and nutrition expert who has completed schooling, supervised practice, and passed a national exam) was not notified that Resident 1 had any PIs until 3/12/26, 10 days after the discovery of Resident 1's coccyx PI, and 7 days after the discovery of the PIs on her heels, and a non-dairy nutrition fortification shake to help with PI wound healing was not obtained until 23 days after the discovery of Resident 1's coccyx PI.These failures had the potential to delay wound healing, lead to infections, and pain for Resident 1.Findings:Review of the National Pressure Injury Advisory Panel NPIAP (a nationally recognized professional resource for the staging and treatment of pressure injuries a global driver of quality improvement and patient safety in healthcare), website document webpage titled, Pressure Ulcer/Injury: Definitions and Etiology https://internationalguideline.com/etiology published February 2025, indicated that other names for pressure injuries include bedsores, decubitus ulcers, pressure sores and pressure ulcers.Review of the National Pressure Injury Advisory Panel's website document titled, NPIAP Pressure Injury and Stages, at https://npiap.com, dated September 2016 indicated;Stage 1 pressure injury: non-blanchable (skin redness or discoloration that does not fade or turn white when pressure is applied) erythema (reddening of the skin), which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature or firmness may precede visual changes.Stage 2 pressure injury: partial-thickness skin loss with exposed dermis (the middle layer of the skin). The wound bed is visible, pink, or red, moist and may also present as an intact or ruptured serum-filled blister (a raised pocket of skin filled with fluid, caused by skin injury from friction [rubbing], heat, or certain diseases. Adipose [fat] is not visible, and deeper tissues are not visible. Granulation tissue may be visible [a type of new, temporary tissue that forms during the wound healing process]). These injuries commonly result from adverse microclimate (temperature and moisture on the skin), and shear in the skin (injury that occurs when skin layers are pulled in opposite directions, damaging tissues, and blood vessels beneath the skin).Unstageable Pressure (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Injury: Obscured (hidden or difficult to see) full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough (thick stringy yellow or gray dead tissue or eschar (black, brown, or tan scab-like dead tissue attached firmly to the wound). If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.Review of Resident 1's health record indicated that she was admitted to the facility on [DATE] with diagnoses which included vertebral fractures (breaks in the bones of the spine).Review of Resident 1's Minimum Data Set (MDS is a federally mandated assessment tool that measures the health status in nursing home residents), dated 2/17/26, indicated a Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 7 out of 15 indicating poor decision making ability.Review of Resident 1's wound care physician consultation dated 3/9/26, completed by the Wound Care Physician (WCP), confirmed that Resident 1 had a stage 2 PI on her coccyx, a stage 2 PI on her left heel, and an unstageable PI on her right heel.1. Review of a facility policy titled, Pressure Injury Prevention revised 6/27/24 indicated 5. Staff will observe for any signs of potential or active pressure injury daily.During a phone interview on 3/12/26 at 4:01 pm, with Licensed Nurse (LN B), LN B indicated that she discovered Resident 1's stage 2 coccyx PI on 3/2/26 and that Resident 1 had been admitted to the facility with no PIs. LN B indicated that PIs do not happen overnight.During a concurrent interview and record review on 3/13/26 at 4:00 pm, with the Director of Nursing (DON), reviewed Resident 1's record titled Skin Check dated 2/24/26 and completed by LN D, the DON acknowledged that there was no mention of a PI on Resident 1's coccyx. Review of Resident 1's record titled N Adv - Long Term Care Evaluation dated 3/4/26 and completed by LN E, the DON acknowledged that the evaluation did not mention PIs on Resident 1's heels. Review of Resident 1's record titled, eINTERACT SBAR Summary for Providers dated 3/5/26 and completed by LN E, the DON acknowledged that this evaluation, done just one day later, indicated that Resident 1 had developed PI wounds on her heels. The DON indicated that this was due to poor assessment skills.2. Review of a facility policy titled, Pressure Injury Prevention revised 6/27/24 indicated 3. Implemented interventions identified in the plan of care which may include, but are not limited to, the following: a. Pressure redistributing devices for bed and chair.During an interview on 3/12/26 at 4:01 pm, with Licensed Nurse (LN B), LN B confirmed that Resident 1 admitted to the facility with no PIs and that she discovered a new stage 2 PI had developed on Resident 1's coccyx on 3/2/26. And that she had put in a request for a low air loss mattress (LAL - a specialized medical mattress designed to prevent and treat pressure ulcers by using inflatable air cells that continuously circulate air, allowing a small amount of air to escape through tiny holes in the mattress that helps keep skin cool and dry) for Resident 1 but she did not know if it was documented.During review of Resident 1's records titled, Orders Summary 2/13/26 to 3/13/26 showed no record for an LAL ordered by LN B was found.Review of Resident 1's record titled, N Adv - Clinical Assessment dated 2/13/26, completed by LN B, indicated that Resident 1 admitted to the facility with no pressure ulcers.Review of Resident 1's record titled, N Adv - Skin Check dated 3/2/26, completed by LN B, indicated a new stage 2 pressure ulcer was found on Resident 1's coccyx with moisture associated skin damage (moisture associated skin damage caused from prolonged exposure to moisture) on her buttocks.During an interview on 3/26/26 at 12:22 pm, with LN A, LN A indicated that on 3/12/26 she looked at Resident 1's skin and ordered a LAL mattress for Resident 1. LN A indicated that the mattress that Resident 1 had before was a standard medical grade mattress, and that this kind of mattress has some pressure relieving qualities but that it was not the mattress that Resident 1 needed.Review of Resident 1's record titled, Order Details (Physician's Order - written instructions from a doctor detailing specific treatments, medications, or tests for a patient) dated 3/13/26, ordered by the Physician (MD), indicated that a LAL was ordered on 3/13/26, 11 days after the discovery of Resident 1's coccyx PI.During a concurrent interview and record review on 3/13/26 at 4:00 pm, with the DON, reviewed Order Details and the DON acknowledged that the Physician's Order for the LAL for Resident 1 was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	obtained on 3/13/26.3. Review of a facility policy titled, Skin Integrity Management revised 6/28/24 indicated, The facility will identify, evaluate, and intervene to prevent further pressure injury and/or heal pressure ulcers and any other skin integrity conditions.Review of a facility policy titled, Skin Integrity Management revised 6/27/24 indicated, b. A Licensed Nurse will complete the skin evaluation weekly.During a concurrent interview and record review on 3/26/26 at 11:19 am, with LN E, LN E indicated that she completed one of Resident 1's weekly summaries on 3/4/26 but did not actually check Resident 1's heels stating, I guess I missed it, sometimes we miss things. LN E explained that the facility has the nursing staff complete the N ADV Skin Check and the N ADV Long Term Care Evaluation. LN E explained that these two assessments are very time consuming and make it difficult to recognize an issue because one includes specific areas of the skin to follow up on from the previous week where there was for example a PI, bruise, or skin tear and another assessment does not indicate a specific area to focus on. LN E indicated that having two redundant assessments made it difficult to recognize Resident 1's heel PIs. LN E indicated that there has been no consistency in how the facility wants them to do things because there has been so much change in the leadership of the facility.Review of Resident 1's change in condition evaluation titled, eINTERACT SBAR Summary for Providers dated 3/5/26 at 2:28 pm, written by LN E indicated that Resident 1 had developed discoloration to the right heel and small open area to left heel measuring 1cm x 1cm (centimeters, a unit of measure, 2.5 cm equals about an inch).During an interview on 3/26/26 at 2:48 pm, with the facility administrator (ADM), Corporate Resource Nurse (CRN), and Regional [NAME] President of Operations (RVPO), the ADM, CRN, and RVPO acknowledged that having two redundant assessments which were not due to be completed at the same time, made recognition of Resident 1's heel PIs difficult.4. Review of a facility policy titled, Pressure Injury Prevention revised 6/27/24 indicated 1. Complete a skin risk evaluation.when there is a significant change in condition.During an interview on 3/26/26 at 10:30 am, with the Minimum Data Set Nurse (MDS - a nurse who completes federally mandated assessments that measure the health status in nursing home residents), the MDS nurse confirmed that there was not a change in condition MDS assessment completed for Resident 1 related to her PIs, that they were just monitoring Resident 1 right now, and that there was an option to not do the change in condition on her at that time.During an interview on 3/26/26 at 2:48 pm, with the CRN, the CRN confirmed that the significant change in condition MDS (SCOC) assessment was not optional and if Resident 1's PIs had not healed within 14 days after discovered, an SCOC MDS should have been completed.5. Review of a facility policy titled, Skin Integrity Management revised 6/27/24 indicated, 5. Review the resident's care plan and update as necessary.Review of Resident 1's record titled, Care Plan dated 3/10/26, indicated that it was not updated to include Resident 1's stage 2 coccyx PI until 3/10/26, 8 days after this PI was discovered, and was not updated to include Resident 1's PIs to her heels until 3/10/26, 5 days after these PIs were discovered.During an interview on 3/13/26 at 4:00 pm, with the DON, the DON confirmed that the care plans for Resident 1's PIs should have been developed right away after their discovery so that a plan was put into place for the interventions necessary to promote healing of Resident 1's PIs.6. Review of a facility policy titled, Skin Integrity Management revised 6/27/24 indicated, d. The dietary needs of the Resident will be evaluated by the registered dietitian upon any significant change in condition.Review of a facility policy titled, Evaluation of Weight and Nutritional Status revised 1/30/25 indicated, 1. The Facility will maintain an acceptable nutritional status for residents per professional standards by: c. Implementing interventions for maintaining or improving nutritional status that are consistent with resident needs.During an interview with the Registered Dietitian (RD) on 3/26/26 at 9:57 am, the RD indicated that she was not notified of Resident 1's PIs until 3/12/26, 10 days after Resident 1's coccyx PI was discovered, and 7 days after the discovery of Resident 1's heel PIs were discovered. The RD indicated that she ordered health shakes 3 times per day to be added to Resident 1's meals on 3/12/26 but that on 3/17/26 she was told by nursing that Resident 1 does not consume dairy products and that they were trying to order Resident 1 a non-dairy health shake. The RD indicated (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she was told that the non-dairy health shake that she suggested was not in the facility's ordering system. The RD confirmed that as of 3/26/26, 24 days after the discovery of her first PI, Resident 1 had still not gotten the non-dairy health shakes.Review of Resident 1's record titled, Nutrition/Dietary Note dated 3/12/26, and written by the RD indicated, Recommend add Health shake TID (3 times per day) with meals.During an interview on 3/26/25 at 2:48 pm, with the RVPO, the RVPO confirmed that the facility went out and purchased the non-dairy health shake that afternoon and that Resident 1 had gotten the first of her non-dairy health shakes that day.