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	04/02/2026

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 observations, interviews, and record reviews, the facility did not identify or implement interventions to ensure the residents were free from accidents or hazards when:1.An unlocked crash cart (a mobile cart that contained lifesaving equipment and medication) was stored in the communal dining room (a large room where residents met to eat meals, participate in activities, or watch TV); and2.Facility nurses did not check two out of two crash carts every night to ensure that needed supplies were available and not expired.This resulted in residents and visitors having access to the contents of the crash cart and had the potential to impact resident safety or cause a delay in life sustaining care.Findings:1.A review of the facility's policies and procedures (P&P) titled, Resident Safety, dated [DATE], indicated, the purpose of the P&P was to ensure residents had a safe and hazard free environment. The P&P indicated that when an unsafe situation was identified, it would immediately be reported to their supervisor.During a concurrent interview and observation on [DATE] at 12:00 pm, with the facility's Infection Preventionist (IP), the crash cart located in the communal dining room was observed. The crash cart was located next to the door, covered with a red cloth cover that was not secured closed and there was no lock. There were residents in the communal dining room waiting for lunch to be served, and no staff were present. Some items located on the crash cart that could be harmful to residents were normal saline (salty, sterile water), an oxygen tank (supplemental oxygen provided to someone who had difficulty breathing on their own), iodine swab sticks (used as first aide to sanitize cuts and scrapes), and Yankauers (a long, hard plastic devise used to suction fluids out of the mouth and throat). Upon leaving the communal dining room, a resident wheeled themselves to the dining table that was within arms reach of the crash cart. IP confirmed the contents of the crash cart were available to residents and stated, that's why we are trying to get a new one that locks.During an interview on [DATE] at 12:28 pm, Director of Nursing (DON) was asked why the facility had one crash cart that was locked and one crash cart that could be accessed by residents. DON could not verbalize a reason and confirmed, the contents of the crash cart in the communal dining room were accessible to the residents and posed a risk to the safety of the residents.During an interview on [DATE] at 3:45 pm, the facility's Administrator (Admin) stated, I am not aware why the crash cart is unlocked and the expectation is the crash cart is to be locked.2.A review of the facility's P&P titled, Medical Emergencies-Code Blue, dated [DATE], indicated there was a signed Emergency Checklist that indicated the crash cart was ready for use.During a concurrent interview, observation, and record review, on [DATE] at 12:00 pm, with the facility's IP, the crash cart located in the communal dining room was observed. The crash cart had a binder that contained untitled documents dated [DATE] through [DATE]. IP indicated the documents were a check list that the night nurses utilized to check the crash carts, every night, to ensure all the supplies were present and nothing on the crash carts were expired. IP reviewed the untitled document on the crash cart located in the communal dining room and confirmed, the night nurses did not document an inspection of the crash cart on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] through [DATE], and [DATE] through [DATE]. IP confirmed, the crash cart contained four packages of Povidone-Iodine Swabsticks (used (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to treat cuts or to sanitize skin) that expired [DATE] and there were no boxes of gloves located on the crash cart.During a concurrent interview, observation, and record review, on [DATE] at 12:15 pm, with the facility's IP, the crash cart located near Station 2 was observed. The crash cart had a binder that contained untitled documents dated [DATE] through [DATE]. IP conf there was no documentation present in the binder that indicated the night nurses had documented an inspection of the crash cart on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] through [DATE], and [DATE] through [DATE]. IP confirmed there was no document in the binder that indicated that night nurses had started a document for [DATE] and confirmed there was no documentation for [DATE].During an interview on [DATE] at 12:28 pm, DON confirmed that it was the DONs responsibility to ensure the night nurses were monitoring the crash carts for expired supplies, needed equipment, and were documenting the crash cart inspections nightly. DON was asked when the last time DON had reviewed the night nurse's crash cart documentation binders and the DON stated, I have not checked recently.