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	04/21/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to ensure sufficient nursing staff were available to meet residents' care needs when:1. Five of five sample residents (Residents 1-5) reported long delays with Certified Nursing Assistants (CNAs) answering call lights and not getting scheduled showers.2. Resident council meetings and resident grievances identified call light response delays during January-March 2026.3. Acuity (complexity and intensity rather than just resident numbers) levels for residents were not considered when scheduling CNA staff on Nursing Station 2.This resulted in missed showers, resident care needs not being met, and residents felt unsafe and disrespected.Findings:1. During an interview on 3/3/26 at 1:30 pm, Resident 2 stated call lights were not answered in reasonable time and has waited 30-40 minutes on the toilet for CNA assistance on Nursing Station 2. Resident 2 stated this caused pain/redness to her legs and bottom. Resident 2 explained CNA staffing on her Nursing Station 2 was three CNAs three days in a row, 3/1-3/3/26. Resident 2 stated there is usually a minimum of four CNAs scheduled and felt five were needed due to so many residents on Hoyer lifts (a mechanical lifting device) to transfer which required two staff. Resident 2 stated delays in assistance feels scary. Resident 2 stated last night staffing was three CNAs. Resident 2 stated she observed a CNA using a Hoyer lift (a mechanical lifting device requiring 2 staff to transfer residents with limited mobility safely between from bed to wheelchair) alone which was not safe. During an interview on 3/3/26 at 1 pm, Resident 1 stated one occasion CNA response was delayed, causing her to yell from room for assistance. Resident 1 stated facility can be short staffed at times, having only 3 CNA staff on Nursing Station 2. Resident 1 stated sometimes there are not enough staff to facilitate smoking breaks for residents. During an interview on 3/4/36 at 1:47 pm, Resident 3 stated she was frustrated with the care provided. Resident 3 stated there are frequent CNA call-offs, and she believes there are not enough CNAs available. She reported that CNAs do not treat all residents the same and stated her roommate requires multiple CNAs for Hoyer lift transfers while she sometimes does not receive assistance when needed. Resident 3 stated she often tries to complete tasks herself but is unable to do so safely. Resident 3 further reported that items are sometimes left blocking the bathroom doorway, and she recalled having to move a dirty brief out of the way to access the bathroom.During an interview on 3/4/26 at 12:20 pm, Resident 4 stated she often must wait a long time to change their incontinence brief, explaining that it depends on staffing and that there were not enough staff available. Resident 4 stated the delays make her feel uncared for and increase her anxiety. Resident 4 stated that CNAs appear to be rushed and do not always leave her feeling completely clean after care. Resident 4 further stated that meals frequently arrive late and are rarely warm. She stated there is not enough CNAs during lunchtime, as CNAs are busy getting residents up, dressed, and transferred using Hoyer lifts.During an interview on 3/4/26 at 12:50 pm, Resident 5 stated she does not believe there are enough CNAs available. Resident 5 stated she often missed her Saturday shower and missed her scheduled shower today. Resident 5 stated CNAs appear stressed and rushed. She stated she feels bad for the CNAs because they work very hard, but due to staffing she does not always receive the care she needs. Resident 5 further stated she is not receiving enough physical or emotional care, and it takes a long time for CNAs to assist her out of (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed. She reported CNAs appear rushed and quickly move to the next resident, and she feels neglected and disrespected.During an interview on 3/3/26 at 12:00 pm, CNA G stated that on recent shifts there were three CNAs assigned to the station, and several residents required Hoyer lift assistance. CNA G stated with this level of staffing we can only do so much. CNA G stated that showers may not always be completed due to workload. CNA G stated the corporation had approved five CNAs for Station 2, and that level of staffing occurred only once, and staffing typically remained at three or four CNAs.During an interview on 3/4/26 at 2:40 pm, CNA B stated the facility was often short-staffed due to call-offs, and staff who call off are not always replaced. CNA B reported residents frequently complain about call light response times.In an interview on 3/4/26 at 2:50 pm, CNA C stated she previously worked the morning shift and transferred to the evening shift because mornings were too busy and assignments were difficult to complete. CNA C stated that when care was completed late, residents sometimes refuse showers which caused showers to be refused or missed.In an interview on 3/4/26 3 pm, CNA D reported that during the morning shift there were initially three CNAs assigned, but one aide left early due to illness, leaving two CNAs for a period of time. CNA D stated the shift was very difficult due to the low staffing level. CNA D stated that showers were not completed and some residents were left wet because CNAs were unable to reach everyone in a timely manner. CNA D stated that four CNAs per station were considered manageable which rarely occurs.2. A review of a Resident/Grievance report dated 2/15/26, indicated Resident 5 reported that a CNA B was not cleaning her thoroughly during personal hygiene care. Resident 5 requested another CNA. A Licensed Nurse on the evening shift informed Resident 5 that she would have to wait for assistance due to the CNAs being busy and would go find a CNA to assist her and never came back.A review of a Resident/Grievance report dated 2/28/26, Resident 2 reported that she had to wait 25 minutes for her bathroom call light to be answered. Resident 2 indicated that on two other occasions when she had initiated her call light, she saw two CNAs walk past her room and did not respond to her request for assistance.A review of Resident Council Meeting Minutes indicated:-On 2/12/26 at 2:30 pm, nine residents attended the meeting and it was reported that call light wait times were at 45 minutes for all nursing shifts.-On 2/24/26 at 2:30 pm, seven residents attended the meeting and it was reported that call light wait times were at 45 minutes for all nursing shifts. CNAs take lunch breaks two at a time and this does not allow enough direct care staff to assist residents.-On 3/10/26 at 2:30 pm, the meeting was attended by nine facility residents who indicated CNAs take lunch breaks two at a time and this does not allow enough direct care staff to assist residents. CNAs assigned to a particular nursing station does not answer call lights while covering for another CNA while on lunch break.3. A review of a mechanical lift (Hoyer) list of residents updated 1/13/25 indicated that on Nursing Station 2 there were 18 dependent residents that required the Hoyer lift. At Nursing Station 1 there were 10 residents listed, for a total of 28 residents who required the Hoyer lift device in the facility.A review of a Bed Bath shower report dated from 1/31/26-3/9/26 for four residents on Nursing Station 2 indicated:-Resident 3's shower schedule days were Wednesday and Saturday on evening shift, she refused showers nine times from 1/31-3/7/26. The showers were offered on the day shift, not the evening shift.-Resident 2's shower schedule days were Wednesday and Saturday on evening shift, she refused her showers seven times from 2/4-3/7/26. The showers were offered on the day shift, not the evening shift.-Resident 4's shower schedule days were Tuesday and Friday on day shift. She refused shower 12 times from 2/3-3/6/26.-Resident 5's 4's shower schedule days were Wednesday and Saturday on day shift. She refused showers seven times from 2/4-3/7/26.A review of the Nursing Staffing Assignment and Sign in Sheets indicated:-On 2/17/26, Nursing Station 2 shift 2:30 pm-10:30 pm, indicated three scheduled CNAs.-On 2/2826, Nursing Station 2 shift 6:30 am-2:30 pm three scheduled CNAs, and shift 2:30 pm-10:30 pm, three scheduled CNAs.-On 3/1/26, Nursing Station 2 shift 6:30 am-2:30 pm three scheduled CNAs.-On 3/2/26, Nursing Station 2 shift 6:30 am-2:30 pm three scheduled CNAs. Shift 2:30 pm-10:30 pm, three scheduled CNAs.During a concurrent interview and record review on 4/21/26 at 11:38 am, the Director of Staff Development (DSD) reviewed staffing (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	schedules and shower documentation for February and March 2026 for Station 2. DSD confirmed that Station 2 had the most Hoyer lifts which meant a higher level of resident acuity and more complex residents with behaviors. DSD confirmed during those months, often they only had three CNAs for Nursing Station 2 when it required four, and now they try to schedule five CNAs. DSD stated they now include acuity in their calculation of needed staff on Station 2 due to the large number of dependent residents that required transfers with Hoyer lifts. DSD stated the Day and Evening shifts should have four CNAs and night shift should have 2. DSD confirmed showers were identified as being refused and missed. DSD stated they have started adding shower CNAs to assist with the workload. DSD confirmed issues with resident showers not happening and resident refusals due to being offered too late.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on interview and record review, the facility failed to provide food that is palatable (refers to the taste and/or flavor of the food), attractive, and nutritious for two of five sampled residents (Residents 2 and 4) who complained of food being cold.This had the potential for all residents to receive an inadequate amount of nutrition required to aid in the recovery from illness or injury or maintain a healthy body weight.A review of a facility policy titled, Menu Operational Manual Policy, revised 04/01/2014, indicated the Dietary Manager will develop menus in collaboration with the Dietitian. Menus are to be designed in consideration of resident preferences, Dietary Department resources, and seasonal availability of food.A record review of monthly Resident Council Meeting minutes from 2/12/24 and 2/24/26, included complaints/concerns regarding food including not being cooked properly (under or overcooked), no condiments (salt, pepper, ketchup, mustard etc.) provided, and no alternative menu items were available.During an interview on 3/3/26 at 1:30 pm, Resident 2 stated her food was cold by the time it gets to her and arrives very late.During an Interview on 3/4/26 at 12:20 pm, Resident 4 stated there was not enough staff during lunch, meals are frequently late and food is rarely warm.A test tray was requested on 4/21/26 at 12:50 pm. Surveyor tasted food items in the presence of the Corporate Certified Dietary Manager (CDM) C. The entree was meatballs and were pale in color and lukewarm (barely warm). green peas which were lukewarm and pasta that was tough, bland in flavor and lukewarm. CDM C had not requested a meal tray to test for herself.During an interview on 4/21/26 at 1:05 pm, CDM C and the Registered Dietician (RD), both confirmed that neither of them had tested any food that was served to the residents or completed audits of meal temperatures and taste, from January to March 2026.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure food was prepared, stored, served, or distributed in accordance with professional standards of food service in a safety manner when:1. [NAME] F did not obtain and document the internal temperature of three of five chicken breast patties prior to serving to residents.2. [NAME] F did not wear gloves when assisting with the plating (putting food on the plate to be served) of a resident's lunch.3. Dietary Aide (DA) placed food in a plastic storage bag with their bare hands.These failures had the potential to result in food contamination which could cause illness for all residents who received food prepared from the facility kitchen. A review of the facility's policy titled, P-D516 Food Temperatures with the effective date of 11/14/2025 indicated, 3. Where To Record Temperature: a. Record the reading on Food Temperature Log at the beginning of the tray line making sure to take the temperature of each pan of product before serving.1. During the lunch meal plating observation 4/21/26 at 11:45 am, five raw chicken patties were on a plate being prepared to fry. The chicken patties were individually fried then placed in covered pan while waiting to be served and no internal temperature was taken.During an interview on 4/21/26 at 1:02 pm, with [NAME] F after the chicken patties were served to the residents, [NAME] F confirmed he had not taken the temperatures of three of the five chicken patties that were served. [NAME] F stated all cooked food should be verified to have a safe internal temperature before serving.During an interview on 4/21/26 at 1:21 pm, Corporate Certified Dietary Manager (CDM) C, confirmed the expectation was to have internal temperatures taken and recorded of all cooked food before serving to residents to ensure the food has reached a safe temperature and avoid food borne illnesses.In an email dated 4/21/26 at 5:06 pm, to the Administrator (ADM), requesting competency evaluations for [NAME] E and [NAME] F, ADM responded neither competencies could be found.2. During a lunch meal observation on 4/21/26 at 12:45 pm, [NAME] E handed a resident plate to [NAME] F to add on a piece of fish. [NAME] F took the plate with his bare hands, used tongs to place the fish onto the plate, then placed the lid on plate without wearing gloves and handed the plate back to [NAME] E. During an interview on 4/21/26 at 1:02 pm, [NAME] F confirmed that gloves are required when handling food and resident meal plates. [NAME] F stated he was in a hurry and forgot to put on gloves when he put the fish on the resident's plate. During an interview on 4/21/26 at 1:47 pm, CDM C confirmed that all kitchen staff are required to wear gloves when handling and plating food. 3. During the lunch meal observation on 4/21/26 at 12:47 pm, DA was putting an onion into a plastic storage bag with her bare hands. DA dropped the onion on the cart and used her bare hands to pick up the onion and put it in the plastic bag.During an interview on 4/21/26 at 1:07 pm, DA acknowledged that gloves should be worn when handling food and confirmed she had forgotten to wear them when putting the onion in a plastic storage bag. DA confirmed the onion she touched without gloves was placed in the refrigerator for use in resident food. During an interview on 4/21/26 at 1:47 pm, CDM C confirmed that all kitchen staff are required to always wear gloves when handling any food, whether it be cooked or raw.