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	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Healthcare Center	375 Cohasset Rd Chico, CA 95926

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat two of three residents (Resident 15 and Resident 17) with respect and dignity when:1. The facility failed to ensure that Resident 17 was provided with appropriate clothing.This failure resulted in Resident 17 experiencing social isolation when unable to participate in facility activities and feeling embarrassed and undignified when required to attend outside appointments wearing only a hospital gown.2. Certified Nursing Assistant (CNA) J did not provide Resident 15 with privacy and dignity when the privacy curtain was not pulled closed when Resident 15 was receiving personal care in their room. This failure resulted in Resident 15 being left vulnerable when staff failed to provide privacy during personal care, potentially causing emotional distress and diminishing Resident 15's sense of dignity and autonomy. Findings: 1. During a review of the facility’s policy titled, Residents Rights – Quality of Life, revised 1/2012, indicated, that residents are encouraged to dress in their own clothing rather than hospital gowns, are to be assisted in attending activities of their choice, and are to be protected from demeaning practices or standards of care that compromise dignity. The policy further states that all residents shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality, and shall receive person-centered services that support them in attaining or maintaining their highest practicable well-being. During a review of the facility’s policy titled, Residents Rights, revised 1/2017, indicated, that the facility is responsible for assisting each resident in exercising their rights by encouraging participation in activities of their choice and incorporating personal preferences, such as dress, into the plan of care. The policy further states that residents are to be provided assistance as needed to engage in their preferred activities on a routine basis. A review of Resident 17’s admission Record indicated that Resident 17 was admitted on [DATE] with diagnoses that included Heart Disease, Diabetes, Depression, and an injury of the right Achilles Tendon (band that connects your calf muscles to your heel bone, enabling one to walk). Resident 17 was their own responsible party (made own decisions). During a review of Resident 17’s Minimum Data Set (MDS, a resident assessment) section C – Cognitive Patterns, dated 7/19/25, indicated that Resident 17 had a Brief Interview for Mental Status (BIMS) score of 11 which indicates moderate cognitive impairment (the ability to understand and make decisions). Resident 17’s MDS section GG – Functional Abilities, dated 7/19/25, indicated that Resident 17 required moderate assistance in dressing above the waist, was dependent (unable to dress themself) for lower body dressing, and required maximum assistance with bathing. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of record titled, “Inventory of Personal Effects”, dated 11/27/24, indicated that upon admission the only article of clothing Resident 17 had were one pair of shoes and one pair of socks. During an interview on 8/19/25 at 9:00 am, Resident 17 stated they have not had clothing during their stay at the facility except for one outfit provided for bingo that was never returned after laundering. Resident 17 reported they remain in a hospital gown and brief (adult diaper) for daily care and outside appointments which prevents participation in activities such as bingo and leaves them feeling embarrassed and undignified. During an interview on 8/20/25 at 2:10 pm, with CNA K, CNA K confirmed that Resident 17 currently does not have any clothing and has not had clothing for at least 3 weeks. Resident 17 was given an outfit out of the facility donations about 3 weeks ago, but it was not returned after going to laundry. CNA K stated they put a note in the Point of Care system but that nothing has changed. During an interview on 8/20/25 at 2:31 pm, Licensed Nurse (LN) D stated that they were not aware that resident 17 did not have any clothing. LN D stated that it was their expectation that if a resident had an appointment outside of the facility that the resident would be dressed before leaving the facility. LN D confirmed that Social Services are the ones who ensured residents had clothing. During an interview on 08/21/2025 at 9:26 am, with Activities Assistant (AA), AA confirmed that Resident 17 has requested to come to the day room for bingo but that they do not have any clothing at this time. At one time they had an outfit that was from facility donations, but it was not returned to the resident after it went to laundry. AA stated that it can be difficult to find Resident 17 clothing because he is a “big guy”. During an interview on 08/21/25 at 10:30 am, with Social Service Assistant (SSA), SSA confirmed that Resident 17 does not currently have any clothing. SSA described the facility’s process for obtaining clothing, which included discussing the resident’s preferences, establishing a trust account with residents who have funds, or purchasing an outfit for the resident if they have no resources. The SSA confirmed that they have not arranged clothing for Residents 17, and that there are currently no donated clothes in the residence size. The SSA stated it is the facilities expectation that residents be showered and dressed before appointments. The SSA further stated it was residence 17's preference to remain in a hospital gown. A review of all of Resident 17’s Social Services Progress Notes from the date of his admission, reflected Resident 17's lack of clothing had not been discussed until 8/21/25, three months after he was admitted to the facility. 2. During an observation on 8/19/25 at 9:15 am, Resident 15 was receiving personal care from CNA J. Resident 15 was in his room in the first bed with two other roommates. CNA J was providing care to Resident 15 which included changing her shirt and incontinence pad (a pad for leakage of urine or stool). CNA J had pulled the curtain by the door, but the two other roommates could see the care that was being provided to Resident 15. There was no other curtain available to provide complete privacy for Resident 15. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/19/25 at 11:06 am, Resident 15 was in bed receiving personal care from CNA J. The privacy curtain was only pulled along the door allowing Resident 15’s roommate to see the care that was being provided by CNA J. Review of Resident 15’s medical record revealed that Resident 15 was admitted on [DATE] with a diagnoses that included Parkinson Disease (a condition that affects a person’s movements), tremors (uncontrollable shaking), and difficulty swallowing. A review of an assessment of Resident 15’s Functional Abilities report dated 6/18/25 indicated that Resident 15 was fully dependent on a caregiver to provide Resident 15 with showers and bathing, toileting hygiene, and dressing the lower body. Resident 15 also needed substantial assistance (caregiver does more than half the effort) to dress the upper body. During an interview on 8/20/25 at 9:55 am, CNA J stated that in Resident 15’s room the curtain does not go all the way around. CNA J stated that there was nothing else that she could do to protect Residents 15’s privacy since the curtain does not go all the way around the bed. During an interview on 8/21/25 at 2:57 pm, with the Director of Staff Development (DSD), the DSD stated that her expectation for CNA’s when providing personal care to residents was for the CNA to introduce themselves, explain what they will be doing for the resident, and pull the curtain closed so no one can see the care that is being provided to the resident and that included the residents roommates even if they are asleep.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to ensure resident council grievances were acted upon and promptly addressed for 12 confidentially interviewed residents when the residents stated there was an ongoing delay in answering call lights and getting care on the night shift. Refer to F726.This failure resulted in residents experiencing frustration with long wait times for needed care and had the potential to put residents at risk for unmet needs.Findings:A review of a facility policy titled, Resident Council revised 11/1/2013, indicated the purpose of the Resident Council was to promote the exercise of resident rights by providing a forum for residents to voice concerns, share input on facility operations, and for the facility to ensure issues raised are reviewed and addressed through the quality assessment and assurance committee. During a review of the facility's record titled, Resident Council Minutes, indicated:a. On 5/13/25, resident council minutes indicated that call light waiting times were still a concern at all times of the day. The response from the Director of Staff Development (DSD, administrative staff responsible for oversight of direct care staff), responded manager to monitor call light, addressed with staff at meeting, everyone answer call light. There were no in-service records provided for the staff meeting to address call light issue. b. On 5/27/25, resident council minutes indicated that call lights were still a concern at all times of the day. Call lights were turned off at night by the Certified Nurse Assistants (CNAs) without the needs of the residents being addressed. The response/action from DSD was a statement ongoing issue mandatory no one walks away. There were no direct care in-services provided or indicated in DSD response. c. On 6/13/25, resident council minutes indicated that night CNA's are taking a long-time answering call lights on both the evening and night shifts. Residents also indicated that registry staff (temporary agency staff) were walking past their call lights without answering them. The Administrator (Admin) response was a written statement in process of hiring new DSD, mandatory everyone answers call lights. There were no direct care staff in-services provided in response to the residents' complaints. d. On 6/24/25, resident council minutes indicated that call lights take a long time to be answered was due to some CNAs taking up to 45 minutes to an hour for resident showers. DSD response was an in-service on shower time management and call light response times. DSD was unable to provide a sign-in sheet for the in-service provided to the direct care staff. A review of an direct care staff in-service titled shower time related to call light response dated 7/8/25, was provided for 17 staff. There was no course content of what was presented or discussed. One of 12 confidentially interviewed residents on 8/19/25 at 10:56 am, stated CNAs on night shift do not answer call lights and when they do provide care, the staff act like they are being bothered. A resident stated that at night, they might have to wait thirty minutes to five hours for their call lights to be answered.One of 12 confidentially interviewed resident on 8/19/25 at 11:50 am, stated the wait time to get their call light answered was concerning. The resident stated that wait times have been as long as two hours that happens daily, but that it was worse at night.During confidential interviews on 8/19/25 at 2:34 pm, seven of 12 residents stated that long waiting times on call lights continue to be a problem, with the longer waiting times being during the night. Four of 12 residents stated that the waiting times are always long. Residents stated that the waiting times are over 30 minutes and that it has been this way for about a year. One of 12 stated that it feels like providing care was not a priority.During a concurrent interview and record review on 8/21/25 at 2 pm, DSD confirmed there needed to be more nursing management oversight on NOC shift to address the call light response times. DSD confirmed there was only one in-service on 7/8/25 that addressed call light response. During a concurrent interview on 8/21/25 at 3:45 pm, with the Admin, Admin confirmed they still have issues with CNA staff performance and competencies with answering call lights timely and they are working on that. Admin confirmed that after four resident council's meetings an in-service was provided for 7/8/25.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three residents sampled for discharge (Resident 61) had the required transfer and discharge documentation in their chart when Resident 61 was transferred to a General Acute Care Hospital (GACH) and: Resident 61 was not provided with a Notice of Transfer or Discharge. Resident 61 was not provided with a notice of a bed hold (holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization).The Ombudsman's office (a government appointed person who actively supports the rights of residents) was not provided with Resident 61's Notice of Transfer or Discharge form. These failures had the potential in Resident 61 not being fully informed of his right to request a bed hold and to return to the facility after hospitalization, and the potential for Resident 61 not having the opportunity to have had an advocate to inform him of his right to appeal a facility-initiated discharge.FindingsA review the facility's policy titled Discharge and Transfer of Residents revised 2/27/25, indicated that prior to discharge, the facility will provide the resident/resident representative with the Notice of Proposed Transfer and Discharge document. A copy of the Notice of Proposed Transfer and Discharge will be placed in the Resident's medical Record and a copy faxed to the ombudsman. Upon transferring to the acute hospital, the resident/resident representative will be given an opportunity to execute a Bed Hold.A review of Resident 61's admission record indicated that Resident 61 was admitted to the facility on [DATE] with acute (sudden) and chronic (occurs again and again for a long time) respiratory failure with hypoxia (low levels of oxygen in the blood), and diabetes (low sugar in the blood). Resident 61 made his own health care decisions.A review of Resident 61's change in condition notes dated 6/24/25 at 00:49 am, Licensed Nurse (LN) O indicated At 00:15 am, Resident (61) had change in O2 (oxygen) levels to 65% (92-100% normal) with O2 at 4L (liters) N/C (per nasal cannula, a tube that delivers oxygen to the nose of a person). Resident (61) refused CPAP (continuous positive airway pressure mask, a breathing assistant device) even when falling asleep. Once CPAP was on resident (61) he continued to decline and became confused and disoriented. He was cold, pale and clammy with no improvement in oxygen. Resident shaking and unable to hold items. MD (medical doctor) notified of condition with order to send out to ER (Emergency Room) for assessment. Resident notified and agreed to send out.During a concurrent interview with the Medical Records Director (MRD) and record review on 8/20/25 at 2:25 pm, Resident 61's medical record was reviewed. MRD indicated that Resident 61 had been admitted to the GACH on 6/24/25 and had not returned to the facility due to Resident 61's increased needs for medical care that they were unable to provide at this facility. MRD searched through Resident 61's medical record and indicated he was unable to find a completed bed hold document, a Proposed Transfer and Discharge document, and verified that the Ombudsman had not been notified of the transfer and discharge for Resident 61's. MRD stated that these documents needed to be completed with each transfer and discharge, but there had been a problem with the nurses not completing these tasks with acute transfers and discharged to the GACH's.During an interview and record review on 8/20/25 at 2:55 pm, Licensed Nurse (LN) C reviewed Resident 61's record of discharge on [DATE] and stated that the bed hold and notice of discharge was never filled out and given to Resident 61 and, there was no verifying fax that the Ombudsman had been notified of the discharge. LN C indicated that this was supposed to have been done. During an interview with the Director of Nursing (DON) and record review on 8/21/25 at 1:22 pm, Resident 61's medical records were reviewed. DON confirmed that the documentation for the bed hold, Notice of Proposed Transfer or Discharge, and the Ombudsman notification of transfer and discharge were not in Resident 61 medical record and they should have been.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper managing of a gastrostomy tube (G-tube, a tube inserted into the stomach through the abdominal wall to deliver liquid nutrition, fluids, and medication) for one of two residents sampled for G-tube management (Resident 45), when the Treatment Nurse (TN) placed Resident 45 in a flat position while the enteral feeding (liquid nutrition and fluids provided through a tube inserted into the stomach) pump was still on.This failure had the potential for the liquid nutrition to back up into Resident 45's esophagus (a tube from the throat to the stomach) and cause aspiration (where liquid nutrition enters the lungs) and can lead to a deadly lung infection called aspiration pneumonia. Findings:The facility policy titled Enteral Feedings was reviewed and the policy indicated The head of bed should be elevated 30 degrees during enteral feedings.A review of Resident 45's admission record indicated Resident 45 was admitted on [DATE] with diagnosis which included stroke (where blood flow to the brain is blocked causing brain cells to die and leading to damage), myotonic muscular dystrophy (a disorder that causes muscle weakness), respiratory failure, dysphagia (difficulty swallowing), and gastro-esophageal reflux disease (a condition where stomach contents frequently leak back into the esophagus).A review of Resident 45's August 2025's physician orders included: An order dated 1/31/25, indicating Enteral Feed Order every shift, Elevate HOB (head of bed) 30-45 degrees during feedings. An order dated 6/20/25, indicating Enteral Feed Order two times a day Jevity 1.5 calories (liquid nutrition that provides complete, balanced nutrition for long- or short-term tube feeding) at 70 ml/hour (milliliters per hour) for 20 hours (on at 4:00 pm, and off at 12:00 pm, the next day to equal 20 hours.)A review of Resident 45's tube feeding care plan revised 5/30/25, indicated The resident needs the HOB elevated 45 degrees during and thirty minutes after tube feeding.During an observation on 8/20/25 at 10:55 am, Resident 45 was observed in bed with the HOB up 90 degrees and the enteral feeding pump on and delivering Jevity 1.5 calories at 70 ml/hour. TN entered Resident 45's room with supplies to change a wound dressing on 45's buttocks. With the tube feeding still running, TN lowered Resident 45's HOB to a flat position and turned her on her side. TN then performed a brief (adult diaper) change and a wound dressing change which was on Resident 45's bottom.During a concurrent observation and interview with TN on 8/20/25 at 11:02 am, (seven minutes later), Resident 45 was observed laying flat in her bed and TN confirmed that the feeding pump had not been turned off while she performed patient cares and it should have been. TN then turned off the feeding until Resident 45's HOB was elevated again.During an interview on 8/21/25 at 12:03 pm, the Director of Nursing (DON) indicated that the tube feeding should be turned off when a resident was laid down and cares were being done.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview and record review, the facility failed to ensure two out of five direct care nursing staff had necessary competencies and skills sets to meet the care and services when: 1. CNA J and F had not worn an N-95 mask (recommended when caring for residents with Covid) when providing care to Resident 28, who had Covid. Refer to F880. 2. CNA J did not ensure privacy for Resident 15 during care. Refer to F550. These failures resulted in resident care needs not to be met, residents' right to privacy violated, and had the potential to spread infection in the facility. Findings: 1. During a concurrent observation and interview on 8/19/25 at 10:52 am, with CNA F, CNA F entered Resident 28's room (who had Covid) with a surgical mask (not as effective against Covid as the N-95 mask), CNA F confirmed she wore a surgical mask. CNA F stated she did not like to wear N-95 masks because, they are too tight. CNA F stated she was aware that the facility's policy was for staff to wear N-95 masks when in Resident 28's room. CNA F stated the Infection Preventionist (IP) had told staff that morning to wear N-95 masks in Resident 28's room. During a concurrent interview and record review on 8/21/25 at 2:33 pm, with IP, the IP could not provide evidence that staff had received education on face mask use. IP could not provide evidence that staff had been educated on caring for residents with Covid. IP stated the expectation was for staff to wear N-95 masks in rooms with residents who had tested positive for Covid. IP confirmed that CNA F staff had not worn an N-95 mask in Resident 28's room and that she should have. 2. During a observation on 8/19/25 at 9:15 am, and 11:06 am, Resident 15 was receiving personal care from CNA J. Resident 15 was in a room with three beds and had the first bed on the right upon entering the room. CNA J was changing her incontinent (poor control of bowels and bladder) pad and shirt for Resident 15. CNA J had pulled the curtain by the door, but the two other roommates could see the care that was being provided to Resident 15. During an observation on 8/19/25 at 11:06 am, Resident 15 was in bed receiving personal care from CNA J. The privacy curtain was only pulled along the door allowing Resident 15's roommate to see the care that was being provided by CNA J. A review of Corrective Action Memo dated 7/28/25, CNA J was assigned to be in the dinning room and left halfway through the meal and did not return. The solution was to not leave the dining room until all residents are done eating. A Corrective Action Memo dated 8/9/25, for unsatisfactory performance CNA J did not provide care to all of CNA J's assigned residents after being informed three times. The note indicated one resident was up since breakfast and was not put to be until 2:30 pm, and another resident had no incontinence brief and had a yellow ring on the pad. The corrective action did not include any objectives or solutions for this performance issue. During a concurrent interview and record review, on 8/21/25 at 2:00 pm with the Director of Staff Development (DSD), the DSD stated that when a CNA receives a corrective action the problem should be identified, they should receive education and supervisory follow-up. DSD confirmed that there are issues with the CNAs on the night shift and that more management oversight was needed to ensure the CNAs were performing their duties. DSD was unable to provide any in-services that were provided for CNA J related to her performance issues. During an interview on 8/21/25 at 3:45 pm, with the Administrator (Admin), Admin confirmed that there were issues with the CNA staff on the night shift, day shift has improved, related to performance and competencies. Admin explained the issue was that the Licensed Nurses (LNs) do not want to oversee the CNAs or manage them. Admin was only able to provide one in-service from July 2025, that was provided to the CNAs on answering call lights. Admin confirmed they still have issues with CNA staff performance and competencies, and they are working on that. Admin stated they have had two DSDs this year as well and now have to replace another one.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to properly store, dispose, and document for the medication that had been discontinued in one of two observed medication rooms (Medication room [ROOM NUMBER]). This had the potential for discontinued medications to be available for resident use and/or diversion (taking without permission), by staff which could negatively impact the residents' health status. A review of facility policy titled, Medication Destruction for Non-Controlled Medications dated 2006, indicated unused, unwanted and non-returnable medications should be removed from their storage area and secured until destroyed. Medication destruction occurs only in the presence of at least two licensed healthcare professionals or according to regulation and applicable law. Licensed healthcare professionals witnessing the destruction ensure that the following information is entered on the medication disposition form.dates, signatures of witnesses.A record review of facility's, Non-Controlled Substance Destruction Log dated 7/23/25, indicated that discontinued medications had been destroyed and the log had not included the signatures of two Licensed Nurses, reasons for destruction, or dates that the medications were destroyed. During a concurrent observation and interview on 8/19/25 at 3:47 pm, medication room one was observed with Licensed Nurse (LN) G. Discontinued medications were observed in a three-tier, unsecured plastic storage container on the floor. LN G confirmed the medications in the plastic bins were not secure and that it would be, too easy for someone to steal those medications. LN G stated that she, had no idea how often discontinued medications were destroyed. LN G stated facility needed a better way of doing it.During an interview and record review on 8/21/25 at 9:51 am, with Director of Nursing (DON), the DON confirmed the facility's Non-Controlled Substance Destruction Log, dated 7/23/25, had not contained the signatures of two Licensed Nurses, dates, or the reasons that the medications had been destroyed, as their facility policy indicated.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility policy and procedure review, the facility failed to ensure visitors and staff who handled food brought from the outside were educated on safe food handling practices. This failure had the potential for unsafe food handling which could lead to foodborne illness in the 53 residents receiving an oral diet who resided in the facility. Findings:During a record review of facility policy titled DD14 Food Brought in by Visitors Revised 4/24/25, indicated food may be brought to a resident by visitors and the facility staff will be made aware of this policy addressing outside food being brought to residents and how to apply it, assist the family/visitors to understand safe food handling practices (such as safe cooling/reheating processes, hot/cold holding temperatures, preventing cross contamination, hand hygiene, etc.), use safe food handling practices when assisting family or visitors with reheating or other preparation activities, and provide resident/resident representative with this policy about the use and storage of [NAME] brought in by family/visitors. During an interview on 8/20/25 at 10:35 am with Licensed Nurse (LN D), when asked about how the food brought to the facility for the residents from the visitors was handled, LN D stated she is not aware of the policy and education was not provided on orientation. LN D stated she has worked at facility for 5 months and believes residents get a handout at admission about safe food handling. During an interview on 8/20/25 at 11:57 am with the Director of Staff Services (DSD). The DSD was asked if she had given an in-service training to the staff members on safe food handling. The DSD stated she has only been here one month, but she will check through the in-service binder. The DSD stated they have changed their orientation competencies, but safe food handling practices are not included. The DSD was unable to provide evidence that facility staff were educated on safe food handling practices. During an interview on 8/20/25 at 10:56 am with the Admissions Coordinator (AC), when asked if she was aware of any information on safe food handling provided to the residents or visitors, the AC stated she was not aware of any education to be provided and confirmed the admission packet did not include safe food handling education for the resident's visitors.

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	08/22/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure their infection control prevention program was implemented to prevent the spread of Covid (a serious virus that causes fever, tiredness, cough, breathing difficulties, loss of smell and taste) when Certified Nursing Assistants (CNAs) were observed wearing surgical masks to care for one resident with Covid (not as effective as an N-95 in preventing the spread of the Covid virus), as their policy directed. (Resident 28) This had the potential to spread the Covid virus to other residents, visitors and staff. During a record review of facility's policy titled, Infection Control - Policies and Procedures date 1/1/12, indicated, The administrator, through the Infection Control Committees, adopts the infection control policies and practices to reflect the facility's needs and operational requirements for preventing transmission of infections and communicable disease as set forth in current CDC guidelines and recommendations.During a record review of CDC's website https://www.cdc.gov/covid/hcp/infection-control/index.html dated 6/24/24, indicated that the Infection Prevention and Control was a set of practices and strategies to stop the spread of infections in healthcare settings. The CDC website recommended, Healthcare Professionals (HCP) who enter the room of a patient with suspected or confirmed SARS-CoV-2 (Covid) infection should.use a National Institute for Occupational Safety and Health (NIOSH) approved particulate respirator (filters small particles of viruses) with N95 (have the ability to filter particulates, while surgical masks do not) filters or higher. During a record review of Resident 28's admission record, he was admitted to the facility on [DATE] with diagnoses that included rhabdomyolysis (muscle damage that affects the kidneys), encephalopathy (brain swelling and confusion or memory loss), and dorsalgia (referring to discomfort in the middle and lower spine region rather than the neck).A record review of Resident 28's care plan dated 8/16/25, indicated he had Covid-19 and was symptomatic with a cough and change in voice.During an interview on 8/19/25 at 9:51 am, with Infection Preventionist (IP), confirmed Resident 28 tested positive for Covid on 8/16/25. IP stated the facility's expectation was for staff to wear N-95 masks when they entered Resident 28's room. During a concurrent observation and interview on 8/19/25 at 10:52 am, with CNA F, CNA F entered Resident 28's room wearing a surgical mask. CNA F confirmed she wore a surgical mask and entered Resident 28's room. CNA F stated she did not like to wear N-95 masks because, they are too tight. CNA F confirmed that she was aware that the facility's policy was for staff to wear N-95 masks when entering Resident 28's room. CNA F stated the IP had told staff that morning to wear N-95 masks when going into Resident 28's room.During a concurrent observation and interview on 8/20/25 at 8:11 am, with CNA J, CNA J entered Resident 28's room wearing a surgical mask. CNA J confirmed that she was wearing a surgical mask, instead of an N-95 mask, and that she was aware that she should have been wearing an N-95.During a concurrent interview and record review on 8/21/25 at 2:33 pm, IP could not provide evidence of staff training on Covid or proper mask use. IP stated the facility's expectation was for staff to wear N-95 masks in rooms with any resident who had Covid.