STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056155	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakdale Nursing and Rehabilitation Center	275 South Oak Avenue Oakdale, CA 95361

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41119 Based on observation, interview and record review, the facility failed to implement a resident-centered comprehensive care plan for one of three sampled residents (Resident 1), when Resident 1 with the known behavior of wandering into other Resident rooms was left unattended on 4/10/24. This failure resulted in Resident 1 entering Resident 2's room where Resident 1 bit the hand of Resident 2. Findings: During a concurrent observation and interview on 4/23/24 at 12:57 p.m. with Resident 1, in Resident 1's room, Resident 1 was seated on her bed. Resident 1 was questioned regarding the altercation on 4/10/24, Resident 1 did not respond to the questions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], it indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of memory and judgment) assessment score was 3 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment, 99 severely impaired). The BIMS assessment indicated Resident 1 had severe cognitive impairment. During an interview on 4/23/24 at 1:01 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 tends to roam into other resident rooms . CNA 1 stated depending on Resident 1's mood, she would attempt to bite her when she did not want assistance with her care. During a concurrent observation and interview on 4/23/24 at 1:12 p.m. with Resident 2, in Resident 2 ' s room, Resident 2 was lying in bed. Resident 2 stated Resident 1 entered her room and was going through her belongings. Resident 2 stated she told Resident 1 to leave her room but Resident 1 told her that it was her room and would not leave. Resident 2 stated it made her feel upset and that Resident 1 bit her hand. During a review of Resident 2's MDS dated [DATE], it indicated Resident 2's BIMS assessment score was 15. The BIMS assessment indicated Resident 2 was cognitively intact. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/23/24 at 1:25 p.m. with Registered Nurse (RN) 1, Resident 1 ' s Care Plan (CP) dated 8/18/23 was reviewed. The CP indicated, .The resident is an elopement [wandering] risk outside of facility and wander risk into other resident rooms r/t [related to] Disoriented to place, History of attempts to leave facility unattended, Impaired safety awareness Dementia [impairment of at least two brain functions, such as memory loss and judgment] .All staff to be aware of residents location. Res [resident] to be distracted away from exit doors, other resident rooms, and dining room . Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book . RN 1 stated Resident 1 has dementia and wonders into other resident rooms. During a concurrent interview and record review on 4/23/24 at 1:30 p.m. with RN 1, Resident 2 ' s Progress Notes (PN), dated 4/11/24 was reviewed. The PN indicated, .Resident was verbally and physically abusive to another resident. CNA's were on break and I was in the process of obtaining vitals [measure the basic functions of your body] and doing my med [medication] pass when a resident from [room number] came to the hall saying her neighbor and another resident were about to get into a fight .witnessed her [Resident 1] and another resident [Resident 2] holding each other's wrists being verbally abusive towards each other . gently pulled them apart and [Resident 2] said Get her the F**k [profanity] out of my room .she [Resident 2] was fine just upset and wanted me to keep [Resident 1] away from her and out of her room . RN 1 stated all staff should monitor Resident 1 so she does not go into other resident rooms. During a review of Resident 1's Abuse Investigation Worksheet (AIW) dated 4/12/24 was reviewed. The AIW indicated, .[Resident 1] .entered room of resident [Resident 2] insisting it was her room [Resident 2] asked [Resident 1] to leave and grabbed her to turn her chair away to have [Resident 1] then bit [Resident 2] on her inner hand between thumb and index finger . During a concurrent interview and record review on 4/23/24 at 2:22 p.m. with the Director of Nursing (DON), the facility policy and procedure (P&P) titled Comprehensive Care Plan dated 03/2001 was reviewed. The policy indicated, . Each resident will have a comprehensive person-centered care plan that includes measurable objectives and time frames to meet his/her, medical, nursing, mental and psychological needs . the comprehensive person centered care plan has been designed to . incorporate identified or potential problem areas . goals and objectives are defined as the desired outcome for a specific problem. They are resident oriented, behaviorally stated . Goals and objectives are entered on the person-centered care plan so that all disciplines have equal access to the information . person centered care plans are initiated and maintained in the resident's electronic record . The DON stated the importance of the care plan was so that all staff was aware of the residents specific care needs. The DON stated that if staff were aware of Resident 1's location, the altercation could have been avoided. During an interview on 4/23/24 at 2:35 p.m. with Resident 3, Resident 3 stated Resident 1 had entered her room before. Resident 3 stated on 4/10/24, Resident 1 entered the room and began to go through her belongings then went over to Resident 2's bed. Resident 3 stated she went to inform the nurse that Resident 1 was in their room. During a review of Resident 3's MDS dated [DATE], it indicated Resident 3's BIMS assessment score was 15. The BIMS assessment indicated Resident 3 was cognitively intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/23/24 at 5:20 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 4/10/24 Resident 3 informed her that Resident 1 and Resident 2 were going to get into a fight. LVN 1 stated that she entered Resident 2's room and observed Resident 1 and Resident 2 holding each other wrists. LVN 1 stated the CNA assigned to Resident 1 was on break and that she was preparing to begin medication pass. LVN 1 stated the importance of the care plan was to ensure staff were following safety protocols to avoid altercations. LVN 1 stated she was not aware that Resident 1 wondered into other resident rooms and that is it was her first time caring for Resident 1. LVN 1 stated staff should have monitored Resident 1 to prevent her from going into Resident 2's room. During a telephone interview on 4/25/24 at 9:31 a.m. with CNA 2, CNA 2 stated she was Resident 1's assigned CNA on 4/10/24. CNA 2 stated when Resident 1 was out of her room she needed to be monitored to prevent her from entering other resident rooms. CNA 1 stated she communicated to the LVN on shift that she was going on break. CNA 1 stated the altercation could have been avoided if Resident 1 was monitored.