STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 39792 Based on interview and record review, the facility failed to identify three instances of abuse, when: 1) One unlicensed staff member withheld food for one resident (unidentified resident) due to the resident's behavior; 2) Staff neglected to change briefs soiled with urine and feces, resulting in skin breakdown (no specific resident was identified) and staff verbally abused a resident (Resident 19), who was one out of one sampled resident. These failures to identify abusive behavior from a staff member toward residents created an environment where residents' rights were violated, and the residents were fearful to report any abusive behaviors from the staff for fear of retaliation. Findings: During a telephone interview on 2/8/24 at 8:35 a.m., a Complainant indicated there were bad things going on between a staff person and the residents, but specifically something happened around 1/25/24, and it was bad. The Complainant indicated the resident involved wanted anonymity and no names were identified. The Complainant indicated, since the Administrator started working at the building in 2022, the residents and staff would not discuss concerns or issues. The Complainant indicated the residents were fearful the building would close if any complaints or issues were brought up to the Administrator. The Complainant indicated the staff turnover had been high since 2022, and the residents did not feel safe with the staff, and the staff would not advocate for them since the staff seem scared of the Administrator. During an interview on 2/15/24 at 11:40 am., in Resident 87's room, Resident 87 was asked if he had been aware of any staff incidents with the residents. Resident 87 indicated things that do not affect him, he would leave alone. Resident 87 was asked if he heard anything since his room was so close to the nurses' station, and he responded with the same message and then abruptly changed the subject to how his hair had turned white overnight. A review of Resident 87's, Annual Assessment, MDS (Minimum Data Set, a clinical assessment process which provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 2/4/24, indicated Resident 87 had a BIMS (Brief Interview of Mental Status) score of 15, indicating zero cognitive impairment. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/15/24 at 11:51 a.m., with Unlicensed Staff A, Unlicensed Staff A indicated she had overheard Unlicensed Staff C yelling at Resident 19 in Resident 19's room. Unlicensed Staff A indicated the words were not distinguishable and could not explain what was said but the tone was hostile and angry. During an interview on 2/15/24 at 12:10 p.m., with Director of Staff Development (DSD), the DSD indicated a licensed staff member (Licensed Staff B) had requested the DSD's presence in meeting with Administrator regarding the behavior of Unlicensed Staff C. The DSD indicated the meeting with the Administrator, the DSD and Licensed Staff B had taken place, and the topic centered around Unlicensed Staff C was not being respectful to the volunteer religious group who had visited the facility during Unlicensed Staff C's shift. Unlicensed Staff C was described by the DSD as being unprofessional to the group of visitors, in the entrance part of the facility and not around the residents. The DSD indicated the behavior of Unlicensed Staff C did not involve other residents and she was not aware of any other incidents with Unlicensed Staff and other residents. During an interview on 2/15/24 at 12:41 p.m with Director of Nursing (DON), the DON indicated, if there were any abuse issues at the facility, he would notify the Administrator who would then report to the Department and other entities. The DON indicated there were no issues with staff altercations and residents. During an interview on 12/15/24 at 1:02 p.m., with Licensed Staff B, Licensed Staff B indicated there had been an issue with Unlicensed Staff C and Resident 19, where Resident 19 requested Unlicensed Staff C to not be her caregiver for the day (2/4/24) because Unlicensed Staff C had yelled at Resident 19. Licensed Staff B indicated Unlicensed Staff C had stated to another resident (unidentified, could not remember name), Is this what I am going to be dealing with this all day? Licensed Staff B indicated Unlicensed Staff C's anxiety was too high, and Unlicensed Staff C was continuing to yell and agitating the other residents. Licensed Staff B indicated Unlicensed Staff C was crying at the nurses' station, later she was observed sitting on the floor in the break room, acting strange, and Licensed Staff B thought Unlicensed Staff C could not finish her shift but was not considered safe to drive home either. Unlicensed Staff C was encouraged to sleep in the car until she was able to drive home safely. Licensed Staff B indicated this was not the first incident, as there had been others and there was a meeting with the DSD and the Administrator regarding the behavior of Unlicensed Staff C, with regards to residents and co-workers. Licensed Staff B indicated, on other instances, Unlicensed Staff C was yelling at residents and making them feel bad and uncomfortable. Licensed Staff B indicated the Administrator was aware of the behavior issues with Unlicensed Staff C. Licensed Staff B indicated she was not aware of the employment status of Unlicensed Staff C and thought maybe the Administrator might have terminated her. During an interview on 2/15/24 at 2:45 p.m., with the Social Services Assistant (SSA), the SSA indicated she was aware of the incident (2/4/24) regarding the behavior of Unlicensed Staff C as she was at the facility the day of the incident. The SSA indicated there were no direct observations of Unlicensed Staff C providing resident care because Unlicensed Staff C was in her car asleep. The SSA indicated Unlicensed Staff C had to stay in the car and sleep the rest of the shift due to her behavior. The SSA indicated, if there were instances of abuse with staff and residents, the Administrator would be notified and report any instance of abuse. The SSA indicated she did not think Unlicensed Staff C was abusive toward the residents and had not been aware of any other instances about Unlicensed Staff C's previous behavior. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/13/24 at 11 a.m., with the Administrator, Unlicensed Staff C's, Untitled Disciplinary Document, dated 1/21/24, was reviewed. The Administrator confirmed the narrative of the document was written by Licensed Staff B who indicated in the document that Unlicensed Staff C would not change residents' briefs, and due to being left soiled for a period of time, the skin had changed color, creating a pink line. Unlicensed Staff C was indicated to refuse changing a resident's (unidentified resident in document) soiled brief of urine and feces because it had been done, and Unlicensed Staff C would not be able to control when residents would soil their briefs or not. Licensed Staff B indicated in the document, that Unlicensed Staff C repeatedly left the residents in her care soiled so when the next shift made rounds (checking on residents visually to see if they required assistance or care) on those residents, they were soaking wet with urine and feces. Licensed Staff B indicated this had been reported to the DON, the DSD and the Administrator without any improvement from Unlicensed Staff C. The Administrator indicated the document reviewed was correct and indicated, leaving a resident soiled and refusing to change a resident was not considered neglect or mental anguish. The Administrator indicated the allegation was investigated, and when Unlicensed Staff C was questioned about the allegation, Unlicensed Staff C denied residents were left soiled for the oncoming shift. The Administrator indicated Licensed Staff B was reputable in reporting the issues, but the results of the investigation indicated no abuse had taken place, and there was no abuse taking place. A review of, Untitled Disciplinary Document, dated 1/22/24, with the Administrator and found to be accurate, indicated Licensed Staff B observed Unlicensed Staff C to be away from residents and found to be asleep for one and one-half hours. The same document noted another dated incident on 12/27/23, where Licensed Staff B indicated Unlicensed Staff C was observed missing during the shift and was found sleeping in her car, and when staff knocked on the window, Unlicensed Staff C would not wake up and did not return to resident care for approximately two and one-half hours. The same document included another incident, dated 1/20/24, where Licensed Staff B indicated during the lunch time meal, Unlicensed Staff C was observed by Licensed Staff B to remove the lunch tray, stating, He can't eat my food, if he acting like that towards me. The Administrator indicated the incident was not considered disciplinary abuse or mental anguish for the resident. The Administrator indicated Unlicensed Staff C was asked about the incident and denied the incident occurred. The Administrator indicated the result of the investigation indicated the incident was not considered abuse. A review of, Untitled Disciplinary Document, dated 2/6/24, was reviewed with Administrator, which indicated Unlicensed Staff C was observed at work, with mental confusion, slurred speech and could not keep her balance and walk appropriately. Unlicensed Staff C was indicated to be yelling at residents and co-workers which was described as dangerous to residents. Licensed Staff B indicted the DON was at the facility during the incident. The document, dated 2/6/24, indicated Unlicensed Staff C was recommended for termination by the DON and Administrator. The Administrator indicated Unlicensed Staff C had reported to work under the, influence, and the Administrator did not agree that having a staff member caring for residents under the, influence or with the described behavior by Licensed Staff B, could be considered abusive to the residents. The Administrator indicated all four instances (12/27/23, 1/21/24, 1/22/24 and 2/6/24) were investigated and found not to be an issue of abuse, but more of a personnel matter, which was why Unlicensed Staff C was terminated from the facility. Resident 19 was unable to be interviewed as the medical record indicated he had been transferred to the hospital on 2/15/24, and wanted to be transferred to another facility rather than returning to the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy titled, Reporting Abuse to Facility Management Policy, dated 11/30/17 indicated, it is the responsibility of our employee, facility consultants, Attending Physicians, family members, visitors etc. to promptly report any incident or suspected incident of neglect .Our facility does not condone resident abuse by anyone, including staff members, physicians, consultants .Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents . or within their hearing distance .Mental abuse is defined as, but is not limited to, humiliation, harassment, threats of punishment, or withholding of treatment or services .Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness .All personnel, residents, family members, visitors, etc. are encouraged to report incidents of resident abuse or suspected incidents of abuse. Such reports may be made without fear of retaliation from the facility or its staff. Employees .must immediately report any suspected abuse or incidents of abuse to the Administrator . In the absence of the Administrator such reports may be made to the director of Nursing or Charge Nurse .any Individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator, Director of Nursing Services, or charge Nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 39792 Based on interview and record the facility failed to identify and report three instances of abuse when the Administrator had documented disciplinary actions (1/21/24, 1/22/24 and 2/6/24) for one unlicensed staff (Unlicensed Staff C) and did not notify the Department. These failures to report abusive behavior from unlicensed staff towards residents created an environment where residents' rights were violated, and the residents were fearful to report any negative behaviors from staff due to retaliation. Findings: During a telephone interview on 2/8/24 at 8:35 a.m., with a Complainant, the Complainant indicated there were bad things going on between a staff person and the residents, but specifically something happened around 1/25/24, and it was bad. The Complainant indicated the resident involved wanted anonymity and no names were identified. The Complainant indicated, since Administrator started working at the building in 2022, the residents and staff would not discuss concerns or issues. The Complainant indicated the residents were fearful the building would close if any complaints or issues were brought up to the Administrator. The Complainant indicated staff turnover had been high since 2022, and the residents did not feel safe with the staff, and the staff would not advocate for them since the staff seemed scared of the Administrator. During an interview on 2/15/24 at 11:40 am., in Resident 87's room, Resident 87 was asked if he had been aware of any staff incidents with the residents. Resident 87 indicated things that do not affect him, he would leave alone. Resident 87 was asked if he heard anything since his room was so close to the nurses' station, and he responded with the same message and then abruptly changed the subject to how his hair had turned white overnight. A review of Resident 87's, Annual Assessment, MDS (Minimum Data Set, a clinical assessment process which provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 2/4/24, indicated Resident 87 had a BIMS (Brief Interview of Mental Status) score of 15, indicating zero cognitive impairment. During an interview on 2/15/24 at 11:51 a.m., with Unlicensed Staff A, Unlicensed Staff A indicated she had overheard Unlicensed Staff C yelling at Resident 19 in Resident 19's room. Unlicensed Staff A indicated the words were not distinguishable and could not explain what was said but the tone was hostile and angry. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/15/24 at 12:10 p.m., with Director of Staff Development (DSD), the DSD indicated a licensed staff member (Licensed Staff B) had requested the DSD's presence in meeting with Administrator regarding the behavior of Unlicensed Staff C. The DSD indicated the meeting with the Administrator, the DSD and Licensed Staff B had taken place, and the topic centered around Unlicensed Staff C was not being respectful to the volunteer religious group who had visited the facility during Unlicensed Staff C's shift. Unlicensed Staff C was described by the DSD as being unprofessional to the group of visitors, in the entrance part of the facility and not around the residents. The DSD indicated the behavior of Unlicensed Staff C did not involve other residents and she was not aware of any other incidents with Unlicensed Staff and other residents. During an interview on 2/15/24 at 12:41 p.m with Director of Nursing (DON), the DON indicated, if there were any abuse issues at the facility, he would notify the Administrator who would then report to the Department and other entities. The DON indicated there were no issues with staff altercations and residents. During an interview on 12/15/24 at 1:02 p.m., with Licensed Staff B, Licensed Staff B indicated there had been an issue with Unlicensed Staff C and Resident 19, where Resident 19 requested Unlicensed Staff C to not be her caregiver for the day (2/4/24) because Unlicensed Staff C had yelled at Resident 19. Licensed Staff B indicated Unlicensed Staff C had stated to another resident (unidentified, could not remember name), Is this what I am going to be dealing with this all day? Licensed Staff B indicated Unlicensed Staff C's anxiety was too high, and Unlicensed Staff C was continuing to yell and agitating the other residents. Licensed Staff B indicated Unlicensed Staff C was crying at the nurses' station, later she was observed sitting on the floor in the break room, acting strange, and Licensed Staff B thought Unlicensed Staff C could not finish her shift but was not considered safe to drive home either. Unlicensed Staff C was encouraged to sleep in the car until she was able to drive home safely. Licensed Staff B indicated this was not the first incident, as there had been others and there was a meeting with the DSD and the Administrator regarding the behavior of Unlicensed Staff C, with regards to residents and co-workers. Licensed Staff B indicated, on other instances, Unlicensed Staff C was yelling at residents and making them feel bad and uncomfortable. Licensed Staff B indicated the Administrator was aware of the behavior issues with Unlicensed Staff C. Licensed Staff B indicated she was not aware of the employment status of Unlicensed Staff C and thought maybe the Administrator might have terminated her. During an interview on 2/15/24 at 2:45 p.m., with the Social Services Assistant (SSA), the SSA indicated she was aware of the incident (2/4/24) regarding the behavior of Unlicensed Staff C as she was at the facility the day of the incident. The SSA indicated there were no direct observations of Unlicensed Staff C providing resident care because Unlicensed Staff C was in her car asleep. The SSA indicated Unlicensed Staff C had to stay in the car and sleep the rest of the shift due to her behavior. The SSA indicated, if there were instances of abuse with staff and residents, the Administrator would be notified and report any instance of abuse. The SSA indicated she did not think Unlicensed Staff C was abusive toward the residents and had not been aware of any other instances about Unlicensed Staff C's previous behavior. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/13/24 at 11 a.m., with the Administrator, Unlicensed Staff C's, Untitled Disciplinary Document, dated 1/21/24, was reviewed. The Administrator confirmed the narrative of the document was written by Licensed Staff B who indicated in the document that Unlicensed Staff C would not change residents' briefs, and due to being left soiled for a period of time, the skin had changed color, creating a pink line. Unlicensed Staff C was indicated to refuse changing a resident's (unidentified resident in document) soiled brief of urine and feces because it had been done, and Unlicensed Staff C would not be able to control when residents would soil their briefs or not. Licensed Staff B indicated in the document, that Unlicensed Staff C repeatedly left the residents in her care soiled so when the next shift made rounds (checking on residents visually to see if they required assistance or care) on those residents, they were soaking wet with urine and feces. Licensed Staff B indicated this had been reported to the DON, the DSD and the Administrator without any improvement from Unlicensed Staff C. The Administrator indicated the document reviewed was correct and indicated, leaving a resident soiled and refusing to change a resident was not considered neglect or mental anguish. The Administrator indicated the allegation was investigated, and when Unlicensed Staff C was questioned about the allegation, Unlicensed Staff C denied residents were left soiled for the oncoming shift. The Administrator indicated Licensed Staff B was reputable in reporting the issues, but the results of the investigation indicated no abuse had taken place, and there was no abuse taking place. A review of, Untitled Disciplinary Document, dated 1/22/24, with the Administrator and found to be accurate, indicated Licensed Staff B observed Unlicensed Staff C to be away from residents and found to be asleep for one and one-half hours. The same document noted another dated incident on 12/27/23, where Licensed Staff B indicated Unlicensed Staff C was observed missing during the shift and was found sleeping in her car, and when staff knocked on the window, Unlicensed Staff C would not wake up and did not return to resident care for approximately two and one-half hours. The same document included another incident, dated 1/20/24, where Licensed Staff B indicated during the lunch time meal, Unlicensed Staff C was observed by Licensed Staff B to remove the lunch tray, stating, He can't eat my food, if he acting like that towards me. The Administrator indicated the incident was not considered disciplinary abuse or mental anguish for the resident. The Administrator indicated Unlicensed Staff C was asked about the incident and denied the incident occurred. The Administrator indicated the result of the investigation indicated the incident was not considered abuse. A review of, Untitled Disciplinary Document, dated 2/6/24, was reviewed with Administrator, which indicated Unlicensed Staff C was observed at work, with mental confusion, slurred speech and could not keep her balance and walk appropriately. Unlicensed Staff C was indicated to be yelling at residents and co-workers which was described as dangerous to residents. Licensed Staff B indicted the DON was at the facility during the incident. The document, dated 2/6/24, indicated Unlicensed Staff C was recommended for termination by the DON and Administrator. The Administrator indicated Unlicensed Staff C had reported to work under the, influence, and the Administrator did not agree that having a staff member caring for residents under the, influence or with the described behavior by Licensed Staff B, could be considered abusive to the residents. The Administrator indicated all four instances (12/27/23, 1/21/24, 1/22/24 and 2/6/24) were investigated and found not to be an issue of abuse, but more of a personnel matter, which was why Unlicensed Staff C was terminated from the facility. Resident 19 was unable to be interviewed as the medical record indicated he had been transferred to the hospital on 2/15/24, and wanted to be transferred to another facility rather than returning to the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy titled, Reporting Abuse to Facility Management Policy, dated 11/30/17 indicated, it is the responsibility of our employee, facility consultants, Attending Physicians, family members, visitors etc. to promptly report any incident or suspected incident of neglect .Our facility does not condone resident abuse by anyone, including staff members, physicians, consultants .Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents . or within their hearing distance .Mental abuse is defined as, but is not limited to, humiliation, harassment, threats of punishment, or withholding of treatment or services .Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness .All personnel, residents, family members, visitors, etc. are encouraged to report incidents of resident abuse or suspected incidents of abuse. Such reports may be made without fear of retaliation from the facility or its staff. Employees .must immediately report any suspected abuse or incidents of abuse to the Administrator . In the absence of the Administrator such reports may be made to the director of Nursing or Charge Nurse .any Individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator, Director of Nursing Services, or charge Nurse .6. Any staff member or person affiliated with this facility who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect or any other criminal offense shall immediately report, or cause a report to be made of the mistreatment or offense. Failure to report such an incident may result in legal/criminal action being filed against the individual(s) withholding such information. A SOC 341 Form will be filled out and faxed to the appropriate agencies as listed on the TLC Mandated Reporter flow chart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39792 Based on interview and record review, the facility failed to send a copy of Notice of Discharge or Transfer to the representative of the Office of the State Long Term Care (LTC) Ombudsman (a public advocate (official) is an official who is charged with representing the interests of the public by investigating and addressing complaints of maladministration or a violation of rights) for four Resident's: Residents 85, was discharged to home, and Residents 86, 87 and 88 were transferred to acute facilities. These failures had the potential for Residents (Resident 85, 86, 87 and 88) were not being provided an advocate who could inform them of their rights and options before being discharge to home or transferred to an acute care facility out of 36 sampled residents. Findings: During a concurrent interview and record review on [DATE] at 2:21 p.m., with Social Services Assistant (SSA), SSA reviewed, a resident who had been discharged and when reviewing the electronic medical record, the progress note did not indicate the resident had been discharged or where the resident had been discharged to. SSA, indicated off the top of her head that the particular resident had been transferred to another facility. SSA indicated if a discharge has been indicated to be a Facility Initiated Discharge (a transfer or discharge which the resident objects to or did not originate), those discharges require a form to be sent to the Ombudsman. SSA indicated she was confused about the form and exactly which discharges require the form. SSA indicated Administrator instructed her to send the form on those discharged the facility initiated not the ones where the resident wants to go home. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 11:00 a.m., with Administrator, reviewed, Admission/Discharge to/From Report, dated [DATE] indicated 40 residents who were had been discharged , transferred, or died at the facility. Administrator was driving and unable to review the document, so each resident was reviewed. Resident 88 was reviewed and indicated to be admitted to the facility on [DATE] and had been discharged on [DATE] after a form indicating Resident 88 no longer qualified for Medicare services. Administrator indicated Resident 88 was considered a Resident Initiated Discharge and thus did not need to be reported to the Ombudsman office. Administrator indicated Resident 88 had been at the facility for months and date of Notice of Medicare Non-Coverage (NOMNC) (form which indicates a date a resident no longer has Medicare coverage and will have to pay for services to remain at the facility) dated [DATE], signed by Resident 88 on [DATE] and the actual discharge date of [DATE] was not considered a Facility Initiated Discharge. Administrator indicated Resident 88 wanted to go home and the NOMNC form just happened to correspond around the same time. Administrator indicated the NOMNC form had to be sent to Resident 88 because she no longer qualified for skilled care. Administrator indicated all of the discharges which occurred from the facility were always resident initiated. Resident 86's transfer to a higher level of care was revied with Administrator. Administrator indicated Resident 86 was transferred out of the facility to a higher level of care on [DATE] and returned on [DATE]. Administrator indicated the Ombudsman office was not notified and could not explain why. Administrator indicated many times a resident will be transferred to a higher level of care emergently only to come back to the facility the same day. Administrator agreed in the situation of Resident 86, that was not the case and the Ombudsman office should have been notified. Resident 87's transfer was reviewed with Administrator. Administrator indicated Resident 87 had been transferred out of the facility to a higher level of care on [DATE] due to vomiting but was discharged on [DATE]. Administrator indicated the Ombudsman office was not notified and was not sure if Resident 87 was discharged from the hospital or from the facility. Resident 88's transfer to a higher level of care was reviewed with Administrator and Resident 88 was transferred out of the facility to a higher level of care on [DATE] and did not return to the facility until [DATE]. Resident 88 was indicated to have had surgery but it was emergent (not scheduled or planned in advance). Administrator agreed the Ombudsman office should have been notified of this transfer as well. Administrator indicated the weekend discharges and especially the residents transferring to a higher level of care would be hard to be compliant with regulation since there would be limited staff on the weekend to take care of the paperwork. Administrator was asked why the facility submitted a policy with an outdated Federal referenced tag and Administrator indicated there was a more current policy. A review of the facility's policy and procedure titled, Transfer and Discharge Notice, dated ,d+[DATE], indicated Reference F 177, did not indicate notifying the Ombudsman office. A review of the facility's policy and procedure titled, Transfer of Discharge Notice, dated 2001, indicated The resident and representatives are notified in writing of the following information: The name, address and telephone number of the Office of the State Long-term Care Ombudsman; .A copy of the notice is sent to the Office of State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident or representative.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41333 Based on interview and record review, the facility failed to coordinate the Level II Preadmission Screening (PASARR) after a positive result for Level I PASARR) for one (1) of eight (8) residents, Resident 17. This failure resulted in a delay of MD's evaluation for mental illness and a delay of care and services needed for Resident 17. Findings: Level II PASARR is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in a nursing home for long term care. A record review of Resident 17 titled Admission record indicated she was initially admitted to the facility on [DATE] with mental illness (MI). A record review of Resident 17's evaluation titled Level I PASARR dated 08/10/21 was positive indicated a Level II PASARR mental health evaluation from Department of Health Services was required. A review of the regulatory health and safety code S 483.20(e)(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. A review of the regulatory health and safety code S 483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Mental Disorder (MD) For purposes of this section, the term mental disorder is the equivalent of mental illness used in the definition of serious mental illness in 42 CFR. A review of regulatory health and safety codes S483.102(b)(1), which states: An individual is considered to have a serious mental illness (MI) if the individual meets the following requirements on diagnosis, level of impairment and duration of illness: (i) Diagnosis. The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised in 1987. This mental disorder is- (A) A schizophrenic, mood, paranoid, panic, or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on interviews and record reviews, the facility failed to ensure: 1. basic care plans (BCP, a plan that promotes continuity of care and communication among nursing home staff to increase resident safety) were completed timely for one out of four sampled residents (Resident 6). 2. the Interdisciplinary Team (IDT, a group of dedicated healthcare professionals who work together to provide you with the care you need) reviewed the physician's order and implement the BCP to meet the residents immediate care needs, initial goals, physician's orders, dietary orders, therapy services, social services and Preadmission Screening and Resident Review (PASRR, Preadmission Screening and Resident Review (PASRR, a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) recommendations if applicable for four out of four sampled residents (Residents 6, 12, 27 and 31). 3. residents or their representative were provided a summary of the BCP for four out of four sampled residents (Residents 6, 12, 27 and 31). These failures had the potential to put residents' safety at risk and for residents to not receive the quality care that they need. A review of Resident 6's face sheet (demographics) indicated he was initially admitted to the facility on [DATE]. His diagnoses included Parkinsonism (a term used to describe the collection of signs and movement symptoms associated with several conditions), Feeding Difficulties (behavioral conditions characterized by severe and persistent disturbance in eating behaviors) and Muscle Weakness. His Minimum Data Sheet Assessment (MDS, a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 2/27/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 3 indicating severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 6's functional status indicated he was dependent on staff assistance during eating. A review of Resident 12's face sheet indicated he was initially admitted to the facility on [DATE]. His diagnoses included Hyperlipidemia (HLP, high cholesterol is an excess of lipids or fats in your blood), Essential Hypertension (HTN, high blood pressure) and Muscle Weakness. His BIMS dated 2/23/24 score was 14 indicating intact cognition. His MDS, dated [DATE] indicated Resident 12 needed up to maximum assistance when performing his ADL. Resident 12 was dependent on staff with lower body dressing and when putting on or taking off his shoes. A review of Resident 27's face sheet indicated his admitted was 2/3/24. Resident 27's diagnoses included Muscle Weakness, Dysphagia (difficulty swallowing) and HTN. His BIMS dated 5/9/24 indicated severe cognitive impairment. His MDS dated [DATE] functional status indicated he was dependent on staff for provision of care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 31's face sheet indicated her admitted was 12/20/23. Her diagnoses included HTN, HLP, and Muscle Weakness. Her MDS dated [DATE] functional status indicated she was dependent on staff with some of her ADLs. Her BIMS dated 5/5/24 score was 11 indicating moderately impaired cognition. During a concurrent interview and BCP records review on 5/22/24 at 9:03 a.m., the Director of Staff Development (DSD) stated the Director of Nursing (DON) should not be the only person present in baseline care planning and stated the IDT, the resident or the responsible party should be involved in Baseline care planning as well. The DSD stated she was not sure if the resident or the RP should receive a copy of the BCP summary. The DSD verified the following information: A. Resident 12's BCP, undated on when it was completed, was not completed by the collaborating efforts of the IDT and the only signature present on Residents 12 BCP was that of the DON. The BCP did not indicate whether the resident or the responsible party (RP, a person who is able to act on behalf of the resident) was involved in developing the BCP. There was also no indication a summary of the BCP was provided to the resident or the RP. B. Resident 31's BCP, undated on when it was completed, was not completed by the collaborating efforts of the IDT and the only signature present on Residents 31's BCP was that of the DON. The BCP did not indicate whether the resident or the RP was involved in developing the BCP. There was also no indication a summary of the BCP was provided to the resident or the RP. C. Resident 6's BCP dated 11/8/22 was completed late on 11/14/22. Resident 6's BCP was not completed by the collaborating efforts of the IDT. Resident 6's BCP did not indicate whether the resident or the RP was involved in developing the BCP. There was also no indication a summary of the BCP was provided to the resident or the RP. Resident 6's BCP was missing information on initial goals and physician's orders. D. Resident 27's BCP, undated on when it was completed, was not completed by the collaborating efforts of the IDT and the only signature present on Residents 27's BCP was that of the DON. The BCP did not indicate whether the resident or the RP was involved in developing the BCP. There was also no indication a summary of the BCP was provided to the resident or the RP. During an interview on 5/22/24 at 9:15 a.m., the Infection Preventionist (IP) stated she was not aware of the time frame for completing a BCP but thought it was supposed to be completed within 72 hours of admission. The IP stated BCP was important for residents' safety and to provide appropriate care. The IP stated baseline care planning involved different department heads and the resident, or the RP should be involved in developing the BCP. When asked if the BCP summary should be provided to the resident or the RP, the IP stated yes. During an interview on 5/23/24 at 2:37 p.m., the DON stated he was the only one who completed the BCP and not the IDT for Residents 12, 27 and 31. The DON also stated the resident, or the responsible party was not involved in developing the BCP for Residents 6, 12, 27 and 31 and the resident or the RP was not provided a copy of the BCP summary for Residents 6, 12, 27 and 31. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/23/24 at 10:46 a.m., the Social Services Director/ Medical Record Director (SSD/MRD) stated the IDT should be completing the BCP along with resident and RP because they could provide invaluable input. The SSD/MRD stated a copy of the BCP summary should be given to the resident and the RP. The SSD/MRD stated it was important the resident and RP be part of BCP to focus on the care that they need to receive at this facility. The SSD/MRD stated not involving the resident or the RP in baseline care planning could put the resident at risk for not receiving the safe care that they need which could result to decreased quality of care and decreased quality of life. A review of the facility's policy and procedure (P&P) titled Care Plans-Baseline, revised 12/2016, the P&P indicated a baseline plan of ca shall be developed within 48 hours of admission . the Interdisciplinary team reviewed the physician's order and implement BCP to meet the residents immediate care needs including but not limited to initial goals, physician's orders, dietary orders, therapy services, social services and PASRR recommendations if applicable .residents or their representative was provided a summary of the BCP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observations, interviews and record reviews, the facility failed to ensure oral care was provided regularly and per plan of care for one out of six sampled residents (Resident 31). This failure led to Resident 31 having a thick whitish, yellowish tinged material on her tongue and could put Resident 31 at risk for dental caries, bad breath and infections. Findings: A review of Resident 31's face sheet (demographics) indicated he was initially admitted to the facility on [DATE]. Her diagnoses included Hyperlipidemia (HLP, high cholesterol is an excess of lipids or fats in your blood), Essential Hypertension (HTN, high blood pressure) and Failure to Thrive (FTT, a decline in older adults that manifests as a downward spiral of health and ability). Her Minimum Data Sheet Assessment (MDS, a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 3/25/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 11 indicating moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 31's functional status indicated she was dependent on staff when performing oral hygiene. During a concurrent observation and interview on 5/20/24 at 4:17 p.m., Resident 31 was noted with buildup of whitish yellowish tinged material on her tongue. Resident 31 could not recall on when was the last time staff had provided oral care for her. During a concurrent observation and interview on 5/21/24 at 1:00 p.m., Resident 31 was still noted with whitish yellowish tinged material on her tongue. Resident 31 could not recall whether staff had provided her oral care. During an interview on 5/21/24 at 1:03 p.m., the Director of Staff Development (DSD) verified Resident 31 had a thick whitish yellowish tinged material on her tongue. The DSD stated this was not acceptable and would have staff provide her oral care now. During an interview on 5/22/24 at 8:25 a.m., the DSD stated staff should provide oral care to the residents at least every shift and as needed. The DSD stated if there were no documentation that an oral care was done, then it meant oral care was not provided for the residents. The DSD stated if oral care was not provided after every meals, then residents would be at risk for tooth decay, tooth aches, pain and mouth infection. During an interview on 5/22/24 at 8:41 a.m., Licensed Staff D stated residents should be offered oral care after every meal per facility policy. Licensed Staff D stated if residents were not provided regular oral care, it could lead to infection, tooth decay, bad breath, loss of appetite, Pneumonia (PNA, an infection of one or both of the lungs caused by bacteria, viruses, fungi, or chemical irritants), and stomach problems. Licensed Staff D stated if the point of care documentation did not indicate they provided oral care, it meant an oral care was not provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/24 at 8:56 a.m., Unlicensed Staff F stated staff should provide oral care to residents after every meal. Unlicensed Staff F stated if there was no documentation that an oral care was provided, then it meant the oral care was not provided. Unlicensed Staff F stated not providing oral care after every meal could put Resident 31 at risk for tooth decay, yeast infection (oral thrush, a mouth infection caused by a yeast fungus) and bad breath. During an interview on 5/22/24 at 9:15 a.m., the Infection Preventionist (IP) stated staff should provide oral care to the residents after every meal. The IP stated if not documented, it meant oral care was not provided. The IP stated not providing an oral care could lead to tooth decay, bad breath, and infection. During a concurrent observation and interview on 5/22/24 at 10:55 a.m., Resident 31 still had whitish yellowish tinged material on her tongue. Resident 31 stated staff did not provide her oral care after breakfast. Resident 31's son verified Resident 31 still had whitish yellowish tinged material on her tongue. During an interview on 5/22/24 at 4:35 p.m., Licensed Staff G stated oral care should be provided to the residents after every meal. Licensed Staff G stated if not documented, it meant the oral care was not provided. Licensed Staff G stated not providing oral care consistently after every meal could lead to cavities, periodontal disease (gum disease, is a serious gum infection that damages the soft tissue around teeth), PNA and infection. A review of Resident 31's point of care (POC, the process of documenting clinical information while interacting with and delivering care to patients) documentation on oral care from 5/1/24 up to 5/21/24 indicated staff were not providing oral care after breakfast. During a concurrent interview and record review of Resident 31's POC documentation on oral care on 5/23/24 at 9:00 a.m., the DON stated staff should perform oral care to resident 31 every shift. The DON verified based on POC documentation, staff were not providing oral care to Resident 31 in the morning, after breakfast. The DON stated not performing oral care to residents every shift or after every meal could lead to bad breath, cavities and infection. A review of the facility's policy and procedure (P&P) titled Activities of Daily Living (ADL), Supporting, revised 3/2018, the P&P indicated residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADL's .appropriate care and services will be provided for residents who were unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (oral care).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41283 46132 Based on observation, interviews and record reviews, the facility failed to ensure for one out of six sampled residents (Resident 12): 1.was using his continuous positive airway pressure (CPAP, a breathing therapy device that delivers air to a mask worn over the nose) every night at bedtime and staff was assisting him on putting on his CPAP mask. 2.staff obtained a physician order for the setting of his CPAP machine. 3.staff put on a no smoking signage in his room since he was using a CPAP. These failures could lead to daytime Fatigue (lack of energy), high Blood Pressure, low oxygen levels, increased Blood Sugar, elevated heart rate, headaches, and mood changes. Findings: A review of Resident 12's face sheet (demographics) indicated he was initially admitted to the facility on [DATE]. His diagnoses included Hyperlipidemia (HLP, high cholesterol is an excess of lipids or fats in your blood), Essential Hypertension (HTN, high blood pressure) and Muscle Weakness. His Minimum Data Sheet Assessment (MDS, a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 2/25/24 indicated Resident 12 needed up to maximum assistance when performing his ADL. Resident 12 was dependent on staff with lower body dressing and when putting on or taking off his shoes. His Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score dated 2/23/24 score was 14 indicating intact cognition. During a concurrent observation and interview on 5/20/24 at 2:54 p.m., a CPAP machine was noted on Resident 12's bedside table on his left side. Resident 12 stated he had not used his CPAP regularly for months now because staff would not assist him in wearing his CPAP mask. Resident 12 stated he had difficulty wearing the CPAP mask by himself due to the location of his CPAP and because of some issue with his hand strength and dexterity when putting on the mask. Resident stated staff would often not help putting on his CPAP mask and would often say, you can do it yourself. Resident 12 stated there was also the plan for a room transfer so that he could have an easier access to his CPAP, but it had not happened yet. Resident 12 stated he wished he could wear his CPAP every night. There was not a no smoking sign noted in his room. Resident 12 stated there was not a no smoking sign posted in his room for as long as he could remember. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/24 at 9:00 a.m., the Director of Nursing (DON) verified Resident 12 had a CPAP. The DON stated he was not aware Resident 12 was not using his CPAP every night. The DON stated nurses should have assisted him in using his CPAP every night. The DON stated the way his CPAP was situated in his room made it difficult for Resident 12 to put on his CPAP so the plan was to change room where Resident 12 could have an easier access to his CPAP. The DON stated since the room change had not happened yet, it was important for staff to assist him on using his CPAP every night. The DON was unable to provide explanation on why the room change had not happened yet. When asked what the risks could be if Resident 12 was not using his CPAP regularly, the DON stated it was a risk for fatigue, low oxygenation level and mood changes. During an interview on 5/23/24 at 11:06 a.m., Licensed Staff D stated it was important to ensure there was a physician order that indicates the proper setting of Resident 12's CPAP machine. Licensed Staff D stated staff should always help Resident 12 put on his CPAP if he requested it no matter what his capabilities were. Licensed Staff D stated Resident 12 not using his CPAP every night meant the physician order was not followed. Licensed Staff D stated not using the CPAP regularly could affect Resident 12's quality of life, he'll feel tired, and could affect his sleep and breathing could be affected as well. During an interview on 5/23/24 at 12:20 p.m., the IP stated staff should ensure there was a physician order regarding the proper setting of Resident 12's CPAP machine. The IP stated it was important to ensure Resident 12 was using his CPAP machine every night. The IP stated if Resident 12 requested for help in putting on his CPAP mask, staff should not ignore his request. The IP stated Resident 12 not using his CPAP every night was a safety risk and could lead to less oxygenation which was a big problem. During a concurrent interview and CPAP physician order dated 4/2/24 record review on 5/23/24 at 2:37 p.m., the DON verified Resident 12 had an order for the CPAP but was missing important components such as setting for oxygen concentration and flow. The DON stated it was important to ensure the setting for Resident 12's CPAP was appropriate to ensure he was getting the amount of oxygen he needed throughout the night for his safety and comfort. During a concurrent observation and interview on 5/23/24 at 5:20 p.m., Licensed Staff D verified there was not no smoking sign posted in Resident 12's room although he was using CPAP. Licensed Staff D stated there should be a no smoking sign posted in his room. Licensed Staff D stated it was important to have this signage in his room to prevent risk of accidents and fire. During an interview on 5/23/24 at 5:24 p.m., the IP stated residents using CPAP should have a no smoking signage posted in their room. The IP stated the no smoking signage could decrease the risks for fire and accidents. A review of the physician order for CPAP dated 4/2/24 did not include the mode and the proper setting for his CPAP machine. A review of the facility's policy and procedure (P&P) titled CPAP/BiPAP Support, revised 3/2015, the P&P indicated to review the physician's order to determine the oxygen concentration and flow .review and follow manufacturer's instruction for CPAP machine set up and oxygen delivery .a no smoking sign for the resident's room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observation, interviews and record reviews, the facility failed to ensure for one out of six sampled residents (Resident 1) 1.in gaining access to hearing services by obtaining an audiologist (a specialist in the treatment of hearing disorders) referral. 2. making an appointment to see an audiologist. 3 .Resident 1's hearing aids (HA, a small electronic devices that amplify sound, help improve hearing and speech comprehension in people with hearing loss) were checked for functionality. These failures led to Resident 1's having difficulty in hearing spoken words. These failures put Resident 1 at risk for miscommunication, frustration and difficulty understanding spoken words. Findings: A review of Resident 1's face sheet (demographics) indicated he was initially admitted to the facility on [DATE]. Her diagnoses included Hyperlipidemia (HLP, high cholesterol is an excess of lipids or fats in your blood), Type 2 Diabetes Mellitus (DM, disease caused by a problem in the way the body regulates and uses sugar as a fuel) and Muscle Weakness. Her Minimum Data Sheet Assessment (MDS, a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 3/15/2024, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 14 indicating intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 1's functional status indicated she needed set up to moderate assistance when performing his Activities of Daily Living (ADL, activities related to personal care which include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). During a concurrent observation and interview on 5/21/24 at 9:58 a.m., Resident 1 was noted to be hard of hearing. Resident 1 stated she was hard of hearing on both ears with her left ear being worse than the right ear. Resident 1 stated she had not been seen by the audiologist and nobody offered it. She stated she had requested to see an audiologist, but she had not seen one up to this day. Resident 1 stated her HA was not working properly. She stated as far as she knew, staff just did not attempt to look into why her HA was not functioning properly and staff did not attempt to put her HA again. During a concurrent observation and interview on 5/22/24 at 9:15 a.m., Resident 1 was not wearing a HA. Resident 1 stated she would like to see an audiologist and would like wear HA again. During a concurrent observation and interview on 5/23/24 at 8:50 a.m., Resident 1 was not wearing a HA. Resident 1 stated she would very much like to see an audiologist and would like to wear HA again. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/24 at 10:03 a.m., the Director of Nursing (DON) stated he was not sure if Resident 1 had been seen by the audiologist. The DON stated Resident 1 need to see an audiologist. The DON verified Resident 1 was hard of hearing (HOH, feeling like speech and other sounds are quiet or muffled, having trouble hearing other people). During an interview on 5/23/24 at 10:40 a.m., the Social Services Director (SSD)/ Medical Records Director (MRD) verified Resident 1 was HOH. The SSD/ MRD stated Resident 1 had not seen an audiologist as far as she could remember. The SSD/MRD stated as far as Resident 1's HOH was concerned; she does not have anything actively pursuing at this time. The SSD/MRD stated the facility had no protocol on how to address issues when resident was HOH. The SSD/MRD stated in hindsight, Resident 1 could have benefitted if she was referred and seen by an audiologist or be fitted with a functioning HA. The SSD/MRD stated not hearing properly could lead to misunderstanding and not being able to get their concerns addressed. During an interview on 5/23/24 at 11:58 a.m., the Activity Director (AD) stated Resident 1 was HOH and should have seen the audiologist to see if anything could help with her hearing. The AD stated difficulty of hearing was a safety risk and would put Resident 1 at risk for miscommunication, not understanding instructions and frustration. During an interview on 5/23/24 at 12:03 p.m., Licensed Staff D verified Resident 1 was HOH and should have seen an audiologist to see if she needed a new HA and to address difficulty of hearing. Licensed Staff D stated residents with difficulty hearing was at risk for miscommunication and frustration. Licensed Staff D stated this was also a dignity issue. During an interview on 5/23/24 at 12:20 p.m., the Infection Preventionist (IP) stated residents who were HOH needs to be seen by the audiologist and be fitted for HA if needed. The IP stated HOH could put residents at risk for miscommunication, residents getting upset, angry and frustrated. During an interview on 5/23/24 2:22 p.m., the DON stated residents' who were HOH should be offered an audiologist referral. The DON stated that in Resident 1's case, the facility had assumed this was discussed between family and the Administrator. When asked if an audiologist referral was offered to Resident 1, the DON stated not to his knowledge. When asked what the risks could be if a resident was HOH, the DON stated it would be a risk for miscommunication and could lead to resident's frustration. During an interview on 5/24/24 at 9:49 a.m., Licensed Staff E stated residents who were HOH were at risk for anger, frustration, refusal of care, miscommunication, and poor care outcome. Licensed Staff E stated Resident 1 was HOH, so the facility would need to notify the physician and request for referral to see what could be done to improve Resident 1's hearing. During a concurrent observation and interview on 5/24/24 at 11:09 a.m., Resident 1 was not wearing a HA. Resident 1 stated nobody had talked to her about getting an audiologist referral and HA although she had mentioned this request to several staff. Resident 1 stated she needed the referral, and the Administrator knew about these requests. A request for the facility's P&P for residents with HOH was requested but was not provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled Activities of Daily Living (ADL), Supporting, revised 3/2018, the P&P indicated residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADL's.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 41283 Based on interviews and record reviews, the facility failed to ensure that one out of four sampled residents, Resident 23, received Range of Motion (ROM- means the extent or limit to which a part of the body can be moved around a joint or a fixed point; the totality of movement a joint is capable of doing. Range of motion of a joint is gauged during passive ROM (assisted) PROM or active ROM (independent) AROM) exercises as ordered by her physician and according to her comprehensive care plan. This failure had the potential to result in the development of new contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) or worsening of contractures to her left and right ankles that could affect her health and well-being. Findings: A review of Resident 23's Admission Record, dated 5/23/24, indicated that her principal diagnosis was Multiple Sclerosis (a chronic degenerative, often episodic disease of the central nervous system marked by patchy destruction of the myelin that surrounds and insulates nerve fibers, usually appearing in young adulthood and manifested by one or more mild to severe neural and muscular impairments, as spastic weakness in one or more limbs, local sensory losses, bladder dysfunction, or visual disturbances). Resident 23's other diagnoses included contractures to left and right ankles, and paraplegia (Paraplegia is a term used to describe the inability to voluntarily move the lower parts of the body. The areas of impaired mobility usually include the toes, feet, legs, and may or may not include the abdomen). A review of Resident 23's MDS, (Minimum Data Set) Section G, Cognitive Patterns, dated 4/9/24, indicated that her BIMS, (Brief Interview for Mental Status) score was 15, meaning she did not have any cognitive (Cognitive means relating to the mental process involved in knowing, learning, and understanding things) impairment. A review of Resident 23's Order Summary Report, active orders as of 5/23/24, indicated that she had an order written by her physician on 11/27/23, which states, RNA (Restorative Nursing Assistant): PROM with bilateral (both) UE (upper extremities), 2-3 times per week or as tolerated. A review of Resident 23's Care Plan, for Multiple Sclerosis, initiated on 1/6/21, indicated the goal, Resident 23 will remain free of complications or discomfort related Multiple Sclerosis through the review date. One of the interventions for this care plan initiated on 1/6/21, indicated, Range of motion (Active or Passive) with AM/PM care daily. During an interview on 5/23/24, at 10:43 a.m., with Unlicensed Staff H, he stated that the person who did RNA left a long time ago. During an interview on 5/23/24, at 11:05 a.m., with Licensed Staff D, she stated that the RNA was the person doing the ROM exercises with the residents. Licensed Staff D stated that facility did not have an RNA for about two months now due to the staff's medical leave of absence. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/24, at 11:30 a.m., with Resident 23, she stated nobody has been doing ROM exercises with her, not the former RNA, nor the CNAs (Certified Nursing Assistants). Resident 23 stated that the CNAs would not know how to do the ROM exercises, nor would they have the time to do it. Resident 23 stated that she needed some ROM exercises on her left leg. During an interview on 5/24/24, at 9:12 a.m., with the Director of Nursing (DON), he stated that the facility did not have the services of an RNA but could not recall for how long. A review of a facility document titled, Restorative Nursing Program, dated 5/28/13, the document indicated on the introduction, Restorative Nursing program is a service provided by the facility generally under nursing, to ensure maintenance of patient's optimum level of function. The patients on this program are encouraged or assisted to achieve and maintain their highest level of self-care and independence. These services must be performed daily. The Restorative Program has four components: 1. Gait /ambulation 2. ROM 3. ADLs (Activities of Daily Living) 4. Feeding The program may also involve occasional wound care patients.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on interviews and record review, the facility failed to ensure a significant weight change was reported to the physician and the Registered Dietician (RD) for one out of six sampled residents (Resident 6), when: 1.Resident 6 lost 12.8 pounds (#, a measure of weight) or 7.6 percent (%, a relative value indicating hundredth parts of any quantity) between 4/2023 and 5/2023. 2.Resident 6 gained 17.8# or 11.5 % between 5/2023 and 8/2023. These significant weight changes, if not reported to the physician and RD, could put Resident 6 at risk for increased mortality and subsequent occurrence of adverse health outcomes. A review of Resident 6's face sheet (demographics) indicated he was initially admitted to the facility on [DATE]. His diagnoses included Parkinsonism (a term used to describe the collection of signs and movement symptoms associated with several conditions), Feeding Difficulties (behavioral conditions characterized by severe and persistent disturbance in eating behaviors) and Muscle Weakness. His Minimum Data Sheet Assessment (MDS, a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 2/27/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 3 indicating severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 6's functional status indicated he was dependent on staff assistance during eating. A review of Resident 6's weight log indicated that on 5/10/2023, Resident 6 weighed 155.2# and on 4/27/2023, Resident 6 weighed 168.0# indicating a 12.8# or 7.6 % weight loss in 1 month. Further review of Resident 6's weight log indicated that on 9/6/2023, Resident 6 weighed 173.0# and on 5/10/2023, Resident 6 weighed 155.2# indicating a weight gain of 17.8# or 11.5% significant weight gain in 4 months. During a concurrent interview and weight log record review on 5/22/24 at 2:55 p.m., the DON stated the weight log information was incorrect, however, there was no documentation to indicate Resident 6 was re-weighed to obtain accurate weight for Resident 6. The DON verified there was no indication the physician was notified of Resident 6's significant weight changes when Resident 6 on 5/10/23 weighed 155.2# and on 4/27/2023, Resident 6 weighed 168.0# indicating a 12.8# or 7.6 % weight loss in 1 month or when Resident 6's weight log indicated that on 9/6/2023, Resident 6 weighed 173.0# and on 5/10/2023, Resident 6 weighed 155.2# indicating a weight gain of 17.8# or 11.5% significant weight gain in 4 months. The DON stated the physician was not notified right away when resident had a significant weight loss when on 5/10/23, Resident 6 weighed 155.2# and on 4/27/2023, Resident 6 weighed 168.0# indicating a 12.8# or 7.6 % weight loss in 1 month. The RD was also not notified when Resident 6 weighed 173.0# on 9/6/23 and 5/10/2023, weighed 155.2# indicating a weight gain of 17.8# or 11.5% in 4 months. The DON stated not reporting significant weight changes to the physician and RD would put Residents 6 health and safety at risk. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/24 at 4:11p.m., the Administrator stated a weight variance of 5# should have been reported to the physician and the RD as soon as possible. The Administrator stated it was important to report significant weight variance to the physician and RD to find out what was going on with the resident and to implement plan that would address resident significant weight changes. During an interview on 5/22/24 at 4:35 p.m., Licensed Staff G stated a weight gain of 17.8 # from 5/2023 to 9/2023 should be reported to the physician and the RD, and a weight loss of 12.8# from 5/2023 to 4/2023 should be reported to the MD and RD as well. Licensed Staff G stated if these significant weight variances was not reported to the physician and the RD, it could lead to malnutrition, further weight loss or weight gain and was a health risk for Resident 6. Licensed Staff G stated significant weight changes should be reported to the physician and the RD so the facility knew what was causing the significant weight changes and the physician and the RD could address the cause of the significant weight changess. During an interview on 5/22/24 at 4:45 p.m., the Administrator stated there was a note from the RD on 5/24/23 which indicated Resident 6 should be re-weighed as the weight taken on 5/10/24 was incorrect. When asked how they knew the weight taken on 5/10/23 was incorrect, the Administrator was silent. The Administrator stated Resident 6 was not reweighed immediately after obtaining an alleged erroneous weight on 5/10/24. The Administrator was not able to find documentation the physician was notified of Resident 6's significant weight changes. The Administrator was not able to find documentation the RD was notified of Resident 6's significant weight gain. During an interview on 5/23/24 at 12:03 p.m., Licensed Staff D stated significant weight loss and weight gain should be reported to the physician and RD. Licensed Staff D stated if significant weight changes were not reported to the physician, it could lead to misdiagnosis, malnutrition, impaired nutrition, and continued weight loss or weight gain. Licensed Staff D stated significant weight changes could affect residents' safety and quality of life. During an interview on 5/23/24 at 12:11 p.m., the Infection Preventionist (IP) stated significant weight gain or weight loss needed to be reported to the physician and RD immediately. The IP stated if significant weight changes were not reported to the physician and the RD immediately, it could result in heart attack, continued weight loss or weight gain, misdiagnosis, inadequate treatment, and malnutrition. During an interview on 5/24/24 at 9:36 a.m., Licensed Staff E stated significant weight changes should be reported to the physician and RD as soon as possible. Licensed Staff E stated a resident weight was a fundamental indicator of good health. Licensed Staff E stated Resident 6's significant weight changes should be reported to the physician and the RD as soon as possible because these significant weight changes were not a normal path of health and the physician need to assess Resident 6 further. Licensed Staff E stated if the physician or the RD was not aware and did not check on Resident 6's significant weight changes, Resident's 6 health could be compromised and it could become a health hazard. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure (P&P) titled Weight Assessment and Intervention revised 9/2008, the P&P indicated any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation .the dietician will review the unit weight record by the 15th of the month to follow individual weight trends over time .a weight loss of 5% in 1 month is significant, greater than 5% was severe, a weight loss of 7.5% in 3 months was significant, greater than 7.5% was severe, and weight loss of 10% in 6 months was significant, greater than 10% was severe .care planning for weight loss or impaired nutrition will be a multidisciplinary effort and will include physician, the nursing staff, the dietician . the dietician will discussed undesired weight gain with the resident and or the family

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on interviews and record reviews, the facility failed to ensure they were adequately staffed when: A.six out of six sampled residents (Residents 12, 13, 20, 24, 27 and 31) complained the facility was short staffed. B. for the month of 4/2024, the total direct care service hours patient per day (DHPPD, staffing requirement) was not met for 24 out of 30 days on these dates: 4/1/24, 4/4/24, 4/6/24, 4/7/24, 4/9/24, 4/10/24, 4/11/24, 4/12/24, 4/13/24, 4/14/24, 4/16/24, 4/17/24, 4/118/24, 4/19/24, 4/20/24, 4/21/24, 4/23/24, 4/24/24, 4/25/24, 4/26/24, 4/27/24, 4/28/24, 4/29/24, 4/30/24 and the Certified Nursing Assistant (CNA) PPD was not met for 28 out of 30 days on these dates: 4/1/24, 4/2/24, 4/3/24, 4/4/24, 4/4/24, 4/5/24, 4/6/24, 4/7/24, 4/8/24, 4/10/24, 4/11/24, 4/12/24, 4/14/24, 4/15/24, 4/16/24, 4/17/24, 4/18/24, 4/19/24, 4/20/24, 4/21/24, 4/22/24, 4/23/24, 4/24/24, 4/25/24, 4/26/24, 4/27/24, 4/28/24, 4/29/24, 4/30/24. C. for the month of 5/2024, the total DHPPD was not met on 6 out of 20 days on these dates: 5/3/24, 5/4/24, 5/5/24, 5/6/24, 5/12/24, 5/18/24 and CNA PPD was not met on 6 out of 20 days on these dates: 5/4/24, 5/5/24, 5/11/24, 5/12/24, 5/17/24, 5/18/24. This failure resulted in residents feeling frustrated and scared nobody could get to them in time if there was a medical emergency. This failure could also put the residents at risk for late provision of care, care not being rendered at all, and increased incidents of falls or accidents. Findings: A review of Resident 12's face sheet (demographics) indicated he was initially admitted to the facility on [DATE]. His diagnoses included Hyperlipidemia (HLP, high cholesterol is an excess of lipids or fats in your blood), Essential Hypertension (HTN, high blood pressure) and Muscle Weakness. His Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) dated 2/23/24 score was 14 indicating intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). His Minimum Data Sheet Assessment (MDS, a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 2/25/24 indicated Resident 12 needed up to maximum assistance when performing his Activities of Daily Living (ADL, activities related to personal care which include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). Resident 12 was dependent on staff with lower body dressing and when putting on or taking off his shoes. A review of Resident 13's face sheet indicated she was readmitted to the facility on [DATE]. Her diagnoses included Stroke (occur when blood flow to the brain is blocked or there is sudden bleeding in the brain) HTN, and HLP. Her MDS dated [DATE] functional status indicated she needed up to maximal assistance when performing her ADLs and her BIMS score was 13 indicating intact cognition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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	A review of Resident 20's face sheet indicated his admitted was 3/1/24. His diagnoses included Muscle Weakness, Compartment Syndrome (a painful condition that occurs when pressure within the muscles builds to dangerous levels) and Seizures (sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain. His MDS dated [DATE] functional status indicated he needed up to maximal assistance when performing his ADLs and was dependent on staff when putting on or taking off his shoes. His BIMS score dated 3/3/24 was 3 indicating intact cognition indicating severely impaired cognition. A review of Resident 24's MDS dated [DATE] indicated his diagnoses included Quadriplegia (a symptom of paralysis that affects all a person's limbs and body from the neck down) Cerebral Palsy (CP, a group of movement disorders that can cause problems with posture, manner of walking (gait), muscle tone, and coordination) and Neurogenic Bladder (lack bladder control due to a brain, spinal cord or nerve problem). His MDS dated [DATE] functional status indicated he needed up to maximal assistance when performing his ADLs but was dependent on staff during toileting, lower body dressing, showering and putting on/off his shoes. His BIMS dated 4/11/24 score was 15 indicating intact cognition. A review of Resident 27's face sheet indicated his admitted was 2/3/24. Resident 27's diagnoses included Muscle Weakness, Dysphagia (difficulty swallowing) and HTN. His BIMS dated 5/9/24 indicated severe cognitive impairment. His MDS dated [DATE] functional status indicated he was dependent on staff for provision of care. A review of Resident 31's face sheet indicated her admitted was 12/20/23. Her diagnoses included HTN, HLP, and Muscle Weakness. Her MDS dated [DATE] functional status indicated she was dependent on staff with some of her ADLs. Her BIMS dated 5/5/24 score was 11 indicating moderately impaired cognition. During an interview on 5/20/24 at 2:54 p.m., Resident 12 stated the facility was short staffed and staff took forever to answer call light. Resident 12 stated staff does not really like it if he asked for help all the time. Resident 12 stated some staff would answer call light after an hour and only after multiple calls. Resident 12 stated sometimes he goes to the nursing station to call staff but even then, he could not find any staff around. Resident 12 stated he wished there were more staff to care for the residents at the facility. Resident 12 stated he felt scared and frustrated. Resident 12 stated nobody comes right away when he needed help. Resident 12 stated staff do not answer call light timely, and he had to wait a long time before staff answers his call light. During an interview on 5/20/24 at 3:35 p.m., Resident 20 stated he does not think there was enough staff at the facility. During an interview on 05/20/24 at 3:37 p.m., Resident 24 stated he hoped the facility staffing improves. Resident 24 stated the facility staffing was bad. Resident 24 stated the Director of Nursing (DON) was often working on the floor because there were no other staff to work on a shift. During an interview on 5/20/24 at 3:44 p.m., when asked if he felt the facility was short staffed, Resident 27 responded yes. Resident 27 stated the facility should have more staff. Resident 27 stated he felt scared nobody would come right away when he needed help. When asked if he had to wait a long time before staff answered his call light, he stated yes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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	During an interview on 5/20/24 at 4:17 p.m., Resident 31 stated the facility was short staffed. Resident 31 stated staff does not come right away if she needed help. During an interview on 5/20/24 at 4:31 p.m., Resident 13 stated the facility was sort staffed. Resident 13 stated staff took a while to answer call lights. Resident 13 stated she had to wait for 30 minutes before staff answered her call light. Resident 13 stated she feel scared no one could come to her in time if there's an emergency. Resident 13 stated when she asked staff why it took them awhile to answer her call light, staff would respond they were short staffed, somebody called off and they had a lot of patients to take care of. During an interview on 5/21/24 at 11:15 a.m., Licensed Staff D stated the facility could benefit from more staffing. Licensed Staff D stated the facility was short staffed sometimes and could use more staff on some days. Licensed Staff D stated short staffing could lead to late provision of care, increased incidence of fall and long wait times for staff to answer call light. During an interview on 5/22/24 at 8:17 am., the Director of Staff Development (DSD) stated short staffing could lead to increased incidents of falls, late provision of care, care not being provided at all and late response to call light. DSD stated insufficient staffing could put residents' safety at risk. During an interview on 5/22/24 qat 8:56 a.m., Unlicensed Staff F stated the facility was short staffed. Unlicensed Staff F stated she had 10 residents to care for this morning. Due to short staffing, Unlicensed Staff F stated sometimes, she was unable to complete her task in an 8-hour period, but she tries her best. Unlicensed Staff F stated it will serve residents' best interest if the facility was not short staffed. Unlicensed Staff F stated short staffing was a safety risk and could result in falls, late provision of care and late response to call light. During an interview on 5/22/24 at 9:15 a.m., the Infection Preventionist (IP) stated short staffing was a safety risk for the residents. The IP stated short staffing could lead to increased incidents of fall, late answering of call lights, increased accidents and late provision of care. During an interview on 5/22/24 at 9:20 a.m., Unlicensed Staff H stated the facility was short staffed. Licensed Staff H stated it would be good for residents if the facility was adequately staffed. Unlicensed Staff H stated short staffing could lead to late provision of care or care not being rendered at all. Unlicensed Staff H stated short staffing put residents' safety at risk. During an interview on 5/22/24 at 4:35 p.m., Licensed Staff G stated the facility was short staffed. Licensed Staff G stated short staffing could lead to decreased quality of care and could put residents' safety at risk for accidents and falls. During an interview on 5/23/24 at 9:00 a.m., when asked if he was aware the facility was not meeting the minimum requirement for DHPPD, the Director of Nursing (DON) stated I'm sure. The DON stated not meeting the DHPPD meant the facility was short staffed and could put residents at risk for falls and delayed care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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	During an interview on 5/23/24 at 10:11 a.m., the Administrator Assistant (AA) stated she was aware they were not meeting the DHPPD and the CNA PPD hours. The AA stated this could mean there were not enough hours for staff to provide direct care to the residents. The AA stated not meeting the DHPPD could result in decreased quality of care and delayed care. A review of Census and DHPPD for all direct care staff and CNAs for the month of 4/2024 indicated: 4/1/24 Actual DHPPD not met 3.39, Actual CNA PPD not met 2.32 4/2/24 Actual CNA PPD not met 2.34. 4/3/24 Actual CNA PPD not met 2.36. 4/4/24 Actual DHPPD not met 3.43, Actual CNA PPD not met 2.33. 4/5/24 Actual CNA PPD not met 2.33. 4/6/24 Actual DHPPD not met 3.44, Actual CNA PPD not met 2.09. 4/7/24 Actual DHPPD not met 3.20, Actual CNA PPD not met 1.84. 4/8/24 Actual CNA PPD not met 2.05. 4/9/24 Actual DHPPD not met 3.45. 4/10/24 Actual DHPPD not met 3.33, Actual CNA PPD not met 2.29. 4/11/24 Actual DHPPD not met 3.45, Actual CNA PPD not met 2.24. 4/12/24 Actual DHPPD not met 3.40, Actual CNA PPD not met 2.30. 4/13/24 Actual DHPPD not met 3.42, 4/14/24 Actual DHPPD not met 3.22, Actual CNA PPD not met 1.96. 4/15/24 Actual CNA PPD not met 2.0. 4/16/24 Actual DHPPD not met 3.29, Actual CNA PPD not met 2.3. 4/17/24 Actual DHPPD not met 3.46, Actual CNA PPD not met 2.25. 4/18/24 Actual DHPPD not met 3.45, Actual CNA PPD not met 2.17. 4/19/24 Actual DHPPD not met 3.48, Actual CNA PPD not met 2.25. 4/20/24 Actual DHPPD not met 3.37, Actual CNA PPD not met 2.13. 4/21/24 Actual DHPPD not met 3.23, Actual CNA PPD not met 1.98. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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	4/22/24 Actual CNA PPD not met 2.18. 4/23/24 Actual DHPPD not met 3.25 Actual CNA PPD not met 2.11. 4/24/24 Actual CNA PPD not met 2.22. 4/25/24 Actual DHPPD not met 3.35, Actual CNA PPD not met 2.17. 4/26/24 Actual DHPPD not met 3.35, Actual CNA PPD not met 2.24. 4/27/24 Actual DHPPD not met 3.37, Actual CNA PPD not met 2.13. 4/28/24 Actual DHPPD not met 3.24, Actual CNA PPD not met 1.99. 4/29/24 Actual DHPPD not met 3.46, Actual CNA PPD not met 2.19. 4/30/24 Actual DHPPD not met 3.21, Actual CNA PPD not met 2.04. For the month of April, the total DHPPD was not met for 24 out of 30 days on these dates 4/1/24, 4/4/24, 4/6/24, 4/7/24, 4/9/24, 4/10/24, 4/11/24, 4/12/24, 4/13/24, 4/14/24, 4/16/24, 4/17/24, 4/118/24, 4/19/24, 4/20/24, 4/21/24, 4/23/24, 4/24/24, 4/25/24, 4/26/24, 4/27/24, 4/28/24, 4/29/24, 4/30/24. For the month of 4/2024, the CNA PPD was not met for 28 out of 30 days on these dates: 4/1/24, 4/2/24, 4/3/24, 4/4/24, 4/4/24, 4/5/24, 4/6/24, 4/7/24, 4/8/24, 4/10/24, 4/11/24, 4/12/24, 4/14/24, 4/15/24, 4/16/24, 4/17/24, 4/18/24, 4/19/24, 4/20/24, 4/21/24, 4/22/24, 4/23/24, 4/24/24, 4/25/24, 4/26/24, 4/27/24, 4/28/24, 4/29/24, 4/30/24. A review of Census and DHPPD for all direct care staff and the CNAs for the month of 5/2024 indicated: 5/3/24 Actual DHPPD not met 3.47, 5/4/24 Actual DHPPD not met 3.4, Actual CNA PPD not met 2.10. 5/5/24 Actual DHPPD not met 3.47, Actual CNA PPD not met 2.16. 5/6/24 Actual DHPPD not met 3.47, 5/11/24 Actual CNA PPD not met 2.35. 5/12/24 Actual DHPPD not met 3.47, Actual CNA PPD not met 2.16. 5/17/24 Actual CNA PPD not met 2.39. 5/18/24 Actual DHPPD not met 3.4. Actual CNA PPD not met 2.10. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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	The total DHPPD not met on 6 out of 20 days on these dates: 5/3/24, 5/4/24, 5/5/24, 5/6/24, 5/12/24, 5/18/24. The CNA PPD was not met on 6 out of 20 days on these dates: 5/4/24, 5/5/24, 5/11/24, 5/12/24, 5/17/24, and 5/18/24. A review of the facility's policy and procedure (P&P) titled Facility Policy Regarding Emergency Staffing Situations , undated, the P&P indicated this P&P will be implemented, effective immediately to ensure appropriate nursing staff to care for their residents .follow AFL DHPPD requirement 3.5/2.4.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 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. 46132 Based on interviews and record reviews, the facility failed to ensure staff have the specific competencies and skill sets necessary to care for residents' needs when: 1.staff did not know what a Baseline Care Plan (BCP, should be developed within 24 hours of admission and contain the minimum health care information necessary to care for the residents) was, and its completion time frame. 2. staff did not know what a Trauma Informed Care (TIC, an approach care that acknowledges the complete picture of a resident's life situation, past and present, to provide effective health care services with a healing orientation and prevent retraumatization) was. These failures could put residents at risk for unsafe, inadequate, and ineffective care. During an interview on 5/22/24 at 8:25 a.m., the Director of Staff Development (DSD) stated she was not aware of what BCP was and stated she did not know the timeframe for completing a BCP. However, the DSD stated if a care plan (CP, a form that summarizes a person's health conditions and current treatments for their care) was not completed timely it could lead to residents' not receiving the care they need. The DSD stated it was a safety risk and could compromise residents' health and safety. The DSD stated she was not aware of what a TIC was and had not provided staff any in service about TIC. During an interview on 5/22/24 at 8:41 a.m., Licensed Staff D stated she was not aware of what a BCP was and its time frame for completion. Licensed Staff D stated care plan was important to ensure residents were being provided with the care they need, and staff were providing care to the residents safely. Licensed Staff D stated she did not know what TIC was and had not received in service on how to care for residents with trauma. During an interview on 5/22/24 at 8:56 a.m., Unlicensed Staff F stated she did not know what TIC was and had not received an in service on how to care for residents with trauma. Unlicensed Staff F stated she would like to receive in service about TIC so she could provide safe and effective care to residents who experienced trauma. During an interview on 5/22/24 at 9:15 a.m., the Infection Preventionist (IP) stated she was not aware of the time frame for completing a BCP but thought it was supposed to be completed within 72 hours of admission. The IP stated BCP was important for residents' safety and to provide appropriate care. The IP stated she was not aware of what TIC was. During an interview on 5/22/24 at 10:40 a.m., the Activity Director (AD) stated she did not know what TIC was and had not receive an in service about TIC. The AD stated she was not aware on how to safely and effectively care for residents who had traumatic experiences in life, but she'll do her best. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/24 at 10:41 a.m. Housekeeping I stated she did not know what TIC was and had not received in service on how to properly respond to residents' negative behavior. Housekeeping I stated she did not know what TIC was. During an interview on 5/22/24 at 10:42 a.m., Unlicensed Staff H stated he did not know what TIC was and had not received an in service about TIC and how to provide safe care for resident that had traumatic experiences in life. During an interview on 5/22/24 at 4:35 p.m., Licensed Staff G stated she was not aware of what BCP was and its completion time frame. Licensed Staff G stated she was not aware of what TIC was and had not received in service on how to properly and safely care for residents who had traumatic experiences in life. During an interview on 5/24/24 at 9:56 a.m., Licensed Staff E stated she had not received in service about TIC. Licensed Staff E stated she would like to know more about TIC because trauma had long impact, it affects residents' health and was a safety issue. Licensed Staff E stated it was important to know about TIC to prevent retraumatization, to increase staff ability to safely care for residents who had traumatic experiences in life, to manage their behavior safely and effectively. Licensed Staff E stated trauma had long impact, it affects health and the health delivery system. A review of the facility's Registered Nurse Competency Checklist and Certified Nursing Competency Checklist indicated BCP and TIC was not included in this checklist. A review of the DSD Mandatory Topics in services did not include BCP and TIC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 39792 Based upon interview and record review the facility failed to have a dedicated full time Director of Nursing. This failure had the potential to put residents at risk for a multi-faceted role of Director of nursing, charge nurse and MDS (Minimum Data Set, a clinical assessment of the resident's functional capabilities and helps staff identify health problems) coordinator whereby the residents were not given the appropriate oversight by a dedicated Director of Nursing. Findings: During an interview on 2/15/24 at 11:05 a.m., Director of Nursing (DON) indicated he was currently the DON, MDS coordinator and floor nurse who administers medications among other duties. During an interview on 2/15/24 at 12:10 p.m., with Director of Staff Development (DSD), DSD indicated DON worked the medication cart passing medication or administering medications to residents every day, (Monday to Friday) DSD indicated the days she would come to work, she would pass medications for DON so he may focus on other duties. DSD indicated if there were issues with the licensed and unlicensed staff then the DON would handle it and then notify the administrator. During an interview on 2/15/24 at 4:11 p.m., DON indicted he was fulfilling the role as DON until Administrator was able to find someone to employ into the role. DON indicated he had been the MDS coordinator for a number of years and would fulfill the DON role when the DON role had been vacated. DON indicated the role of DON had been vacant since 2022 and he had been fulfilling the role ever since. DON indicated there had been no interviews or observable indication that the DON position was attempted to being actively filled. DON indicated he would be expected to pass or administer medications Monday through Friday on half of the residents within the facility, handle all pharmacy related tasks, like ensuring medications were ordered, received and doses changes for medications were reviewed and updated in the medical record. DON indicated part of the DON role was to ensure the pharmacist recommendations and physician follow up occurred especially with regard to gradual dose reduction of certain medications for residents. DON indicated this was very time consuming along with handling the admissions and discharging of residents at the facility. DON indicated there were additional pharmacy type issues he was expected to handle at the facility for all of the residents which made being able to function as a full time DON impossible. A review of Resident 19's MDS record, Quarterly Assessment Review dated, 1/31/22, 4/25/22, 10/24/22, 1/24/23, 4/26/23, 10/25/23 and 1/25/24 was completed and documented by DON. During a review of Resident 16's, MDS record, Quarterly Assessment Review, dated 3/23/22, 6/23/22, 12/22/22, 3/24/23, 6/24/23, 9/22/23 and 12/23/23 was completed and documented by DON. During a review of Resident 84's, MDS record, Quarterly Assessment Review, dated 3/22/22, 6/22/22, 9/22/22, 3/23/23, 6/23/23 and 9/23/23, was completed and documented by DON. During a review of Resident 84's, MDS record, Annual Assessment, dated 2/9/24 was completed and signed by DON. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 18's MDS record, Quarterly Assessment Review, dated 6/7/22, 9/7/22, 12/8/22, 6/8/23, 9/8/23 and 12/9/23, was completed and documented by DON. A review of Resident 19's, Medication Administration Record, dated 11/23, indicated DON administered medications to Resident 19 on 21 days (11/1/23, 11/2/23, 11/3/23, 11/6/23, 11/7/23, 11/8/23, 11/9/23, 11/10/23, 11/13/23, 11/14/23, 11/15/23, 11/16/23, 11/17/23, 11/20/23, 11/21/23, 11/22/23, 11/23/23, 11/24/23, 11/27/23, 11/28/23 and 11/29/23 out of a total of 31 days. A review of Resident 16's, Medication Administration Record, dated 11/23, indicated DON administered medications to Resident 16 on 21 days (11/1/23, 11/2/23, 11/3/23, 11/6/23, 11/7/23, 11/8/23, 11/9/23, 11/10/23, 11/13/23, 11/14/23, 11/15/23, 11/16/23, 11/17/23, 11/20/23, 11/21/23, 11/22/23, 11/23/23, 11/24/23, 11/27/23, 11/28/23 and 11/29/23 out a total of 31 days. A review of Resident 84's, Medication Administration Record, dated 11/23, indicated DON administered medications to Resident 84 on 21 days (11/1/23, 11/2/23, 11/3/23, 11/6/23, 11/7/23, 11/8/23, 11/9/23, 11/10/23, 11/13/23, 11/14/23, 11/15/23, 11/16/23, 11/17/23, 11/20/23, 11/21/23, 11/22/23, 11/23/23, 11/24/23, 11/27/23, 11/28/23 and 11/29/23 out of a total of 31 days. During a review of Resident 18's, Medication Administration Record, dated 11/23, indicated DON administered medications to Resident 18 on 20 days (11/1/23, 11/2/23, 11/3/23, 11/6/23, 11/7/23, 11/8/23, 11/9/23, 11/10/23, 11/13/23, 11/14/23, 11/15/23, 11/16/23, 11/20/23, 11/21/23, 11/22/23, 11/24/23, 11/27/23, 11/28/23 and 11/29/23 out of a total of 31 days. During a review of Resident 18's, Medication Administration Record, dated 12/23, indicated DON administered medications to Resident 18 on 18 days, (12/1/23, 12/4/23, 12/5/23, 12/7/23, 12/8/23, 12/11/23, 12/12/23, 12/15/23, 12/18/23, 12/19/23, 12/20/23, 12/21/23, 12/22/23, 12/25/23, 12/26/23, 12/27/23, 12/28/24 and 12/29/24) out of a total of 31 days. During a review of Resident 19's, Medication Administration Record, dated 12/23, indicated DON administered medications to Resident 19 on 18 days, (12/1/23, 12/4/23, 12/5/23, 12/7/23, 12/8/23, 12/11/23, 12/12/23, 12/15/23, 12/18/23, 12/19/23, 12/20/23, 12/21/23, 12/22/23, 12/25/23, 12/26/23, 12/27/23, 12/28/24 and 12/29/24) out of a total of 31 days. During a review of Resident 16's, Medication Administration Record, dated 12/23, indicated DON administered medications to Resident 16 on 18 days, (12/1/23, 12/4/23, 12/5/23, 12/7/23, 12/8/23, 12/11/23, 12/12/23, 12/15/23, 12/18/23, 12/19/23, 12/20/23, 12/21/23, 12/22/23, 12/25/23, 12/26/23, 12/27/23, 12/28/24 and 12/29/24) out of a total of 31 days. During a review of Resident 18's, Medication Administration Record, dated 12/23, indicated DON administered medications to Resident 18 on 18 days, (12/1/23, 12/4/23, 12/5/23, 12/7/23, 12/8/23, 12/11/23, 12/12/23, 12/15/23, 12/18/23, 12/19/23, 12/20/23, 12/21/23, 12/22/23, 12/25/23, 12/26/23, 12/27/23, 12/28/24 and 12/29/24) out of a total of 31 days. During a review of Resident 19's, Medication Administration Record, dated 1/24, indicated DON administered medications to Resident 19 on 16 days (1/2/24, 1/4/24, 1/5/24, 1/9/24, 1/10/24, 1/11/24, 1/12/24, 1/15/24, 1/16/24, 1/17/24, 1/18/24, 1/19/24, 1/23/24, 1/24/24, 1/25/24 and 1/29/24 out of a total of 31 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Requested policy on Director of Nursing job description and the facility did not provide one.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 46132 Based on observations, interviews and record reviews, the facility failed to ensure: 1. staffing information was posted in a prominent place readily accessible to residents and visitors, when the nursing staffing information was kept in a binder behind the counter at the nursing station 2. staffing information was accurate and current. 3. staffing information was complete and was not missing information when the nursing home patient per day (NHPPD, the actual nursing hours performed by direct caregivers per patient day) was left blank. These failures resulted in the nurse staffing information being inaccessible to residents and visitors at any given time and the facility not meeting the NHPPD staffing requirement (cross reference F725). Findings: During an observation on 5/20/24 at 4:00 p.m., there was no visible staffing information posted in the building or at the nursing station. During a concurrent observation, interview, and staffing information, dated 5/21/24, record review on 5/21/24 at 11:15 a.m., Licensed Staff D verified there was no visible staffing information posted in the building or at the nursing station because this information was kept in a binder behind the counter at the nursing station. When asked if the staffing information in the binder behind the counter at the nursing station was accessible to residents and visitors, Licensed Staff A stated no. Licensed Staff D verified the staffing form did not have information on NHPPD and was not signed by the Director of Nursing (DON) or the designee. During a concurrent observation, interview, and staffing information dated 5/21/24 and 5/22/24 review on 5/22/24 at 8:17 a.m., the Director of Staff Development (DSD) verified there was no visible staffing information posted in the building or at the nursing station because this information was kept in a binder behind the counter at the nursing station. The DSD stated the staffing information was not readily accessible if the staffing information was kept in a binder behind the counter at the nursing station.The DSD stated she did not know what NHPPD meant. The DSD verified the staffing form dated 5/21/24 and 5/22/24 did not have information on the NHPPD and were not signed by the DON or designee. The DSD stated that it would be good if the NHPPD was computed daily to ensure the facility was following the regulation and there were sufficient staff to care for the residents at the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/24 at 8:41a.m., Licensed Staff D stated the NHPPD calculation was not being done daily. Licensed Staff D stated she did not have an idea of whether the daily NHPPD was being met. Licensed Staff D stated it was important the NHPPD was computed daily to ensure the facility was following the regulation and there were sufficient staff to care for the residents at the facility. Licensed Staff D stated the staffing information should be posted in a visible and accessible area. During an interview on 5/22/24 at 10:00 a.m., the Administrator Assistant (AA) stated she does not fill out the NHPPD portion of the staffing form daily. The AA stated she only filled out the NHPPD information on the staffing form every 2 weeks during pay period. The AA stated she kept the staffing information in a binder behind the counter at the nursing station. When asked if keeping the staffing information in a binder behind the counter at the nursing station made it readily accessible to the residents or the visitors, the AA stated no. The AA stated she always did it this way. During an observation on 5/23/24 at 8:35 a.m., there was still no visible posting of staffing and NHPPD information in the building or at the nursing station. During an interview on 5/23/24 at 9:00 a.m., the Director of Nursing (DON) stated he had no idea the staffing information should be posted so it was readily accessible to residents and visitors. When asked if keeping the staffing information in the binder behind the nursing station counter made it readily accessible to residents and visitors, the DON stated no. The DON verified he also does not sign off on any of the NHPPD staffing information and was not aware the Administrator Assistant was only calculating the NHPPD every 2 weeks. During an interview on 5/23/24 at 10:11a.m., the AA stated she was not aware the NHPPD information should be posted. The AA verified the staffing information was kept in a binder behind the nursing station counter. When asked if this location seemed accessible, she did not respond. During an observation on 5/23/24 at 10:54 a.m., the staffing information was still not posted in a visible area in the building or at the nursing station. The facility policy and procedure for nurse staffing posting was requested but was not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41333 Based on observation, interview and record review, the facility failed to ensure that all controlled discontinued medication were stored securely and only authorized Licensed staff such as the Director of Nursing (DON) had the key to the storage. The individual medication packets were not labeled according to the Doctor's order when: a) Discontinued controlled medications were not properly secured. Missing discontinued control medications such as narcotics were identified. Unauthorized Licensed Staff Nurse had a direct access to the locked storage for discontinued medication. b) Inaccurate labeling of the individual medications from the Pharmacy dispensed apparatus. The label did not indicate the route, and durations ordered by the Doctor. This failure had the potential for drug diversions by Licensed Nurse and medication administration error. Findings: (a) During a concurrent observation and interview on 5/22/24 at 12:39 pm, the DON stated that he destroyed all discontinued controlled medications (Controlled Medications are substances that have an accepted medical use (medications which fall under US Drug Enforcement Agency (DEA) Schedules II-V), have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence) with the Pharmacist consultant once a month during the Medication Regimen Review (MRR). The DON showed the container where he stored all discontinued controlled medications before destroying in the presence of the pharmacist. The black tin can box container was in the unused portion of the building with double lock. The black tin can box was locked with key but not securely vaulted on the counter. During a review of the discontinued controlled medications on 5/22/24, a bubble pack medication called Hydroco/APAP 5-325MG (Norco) was submitted with six (6) tablets on the reconciliation sheet. The actual number of Norco in the bubbled pack was five (5) tablets. This bubble pack was missing one tablet of Norco. Another bubble pack for oxycodone tablet (Percocet) indicated that medications to be given 1/2 tablet. In the reconciliation sheet did not indicate when the Percocet was given 1/2 tablet or whole. The reconciliation sheet did not indicate any wasted medication. Another individually wrapped Percocet counted as six (6) and in the reconciliation sheet, indicated there were eight (8) tablets was submitted to be destroyed. This individual wrapped Percocet was missing two tablets. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/23/24 at 3:56 p.m. with the Pharmacist, she said that she had noted that missing narcotic in January 2024 during the destructions of other medications. The Pharmacist stated that during the medication destruction on January 2024, she informed the DON that there were some missing tablets of controlled medications. The Pharmacist stated that the DON would investigate for the missing controlled medications. During an interview on 05/23/24 at 04:02 p.m., the Administrator (ADM) stated that she was not aware of any missing controlled medications. The ADM stated that she just learned now when this surveyor informed her. The ADM stated that the DON did not tell her about the missing controlled medications. During an interview on 05/23/24 at 04:12 p.m. the DON, stated that he knew about the missing controlled medications and said that he spoke to the Licensed Nurse J (LN) and had her signed the reconciliation sheets the amount she submitted. The DON stated that he could not remember the reason for missing controlled medications. During a telephone interview on 05/23/24 04:15 p.m. LN J (Licensed Nurse who placed the discontinued controlled medication in the box) stated that she was the charge nurse for the night shift with two Certified Nursing Assistant. LN J stated that when there was a discontinued controlled medication, she would get the DON's key in the office and put the discontinued medication in the black tin box. LN J stated that she would go to the black tin box alone since there was no other Licensed Nurse available. When asked LN J if that was her job duty to put the controlled medications away, LN J stated No. LN J stated that she was helping and that she bought that black tin box container for the facility. LN J stated that when she brought the bubbled pack of Norco it had eight (8) tablets, not six (6). LN J stated that she was not aware of what happened to the missing controlled medications. (b) During a concurrent interview and record review on 05/22/24 3:15 p.m., of the medication administration record (MAR), Doctor's order and medication label in individual packet came from an apparatus that prints out the medication label. The medication label did not have the same order written as ordered by the doctor. The medication did not reflect the route and duration. Pharmacist Manager stated that the labeling on individual medicine packet did not require a direction of route and duration. The Pharmacist Manager did not provide a Policy & Procedure of the Medication labeling. 46132 Based on observations, interviews and record reviews, the facility failed to ensure for one out of eight sampled residents (Resident 12): 1. all his medications were secured in a locked storage area with limited access to authorized personnel consistent with state or federal requirements and professional standards of practice. This failure resulted in unsecured and unsafe storage of all the medications of Resident 12 which was a huge safety risk not only to Resident 12 but also to the other residents at the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. the facility followed their procedures for ensuring his safety when he was self-administering his medications. This failure put Resident 12 at risk for accessing and ingesting medications that could cause clinically significant adverse consequences, worsening of his symptoms which could also result to serious harm or death. Findings: A review of Resident 12's face sheet (demographics) indicated he was initially admitted to the facility on [DATE]. His diagnoses included Hyperlipidemia (HLP, high cholesterol is an excess of lipids or fats in your blood), Essential Hypertension (HTN, high blood pressure) and Muscle Weakness. His Minimum Data Sheet Assessment (MDS, a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 2/25/24 indicated Resident 12 needed up to maximum assistance when performing his ADL. Resident 12 was dependent on staff with lower body dressing and when putting on or taking off his shoes. His Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score dated 2/23/24 score was 14 indicating intact cognition. During a concurrent observation and interview on 5/20/24 at 3:12 p.m., it was noted Resident 12 had over the counter (OTC, drugs you can buy without a prescription) topical medications such as antifungal powders and topical pain medication on the shelf on the left side wall of Resident 12's room. It was also noted on Resident 12's bed, a yellow, red, blue and purple colored large medication pill box. Resident 12 stated he had these OTC medications in his room for months. Resident 12 stated the nurses, and the Director of Nursing (DON) were aware he was keeping these OTC medications in his room. Resident 12 stated he was not sure if there was a physician order for him to keep his OTC medications. Resident 12 stated he was not sure if the physician had an order for his OTC medications as well. Resident 12 stated nobody from the facility had assessed if it was appropriate for him to self-administer his OTC medications or if it was safe to keep his OTC medications in his room. During an observation on 5/21/24 at 11:57 a.m. Resident 12 still had OTC topicals kept in his room by the shelf on the left side of the wall. Resident 12's yellow, red, blue and purple colored large medication pill box was on his bed. During an interview on 5/23/24 at 9:00 a.m., the Director of Nursing stated Resident 12 should not keep any OTC medications in his room. The DON stated the facility did not notify the physician Resident 12 was keeping OTC medications in his room. The DON verified there was no self-administration assessment completed for Resident 12. The DON stated Resident 12 was not allowed to self-administer medications and store medications in his room for safety purposes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/23/24 at 11:06 a.m., Licensed Staff D stated Resident 12 was not supposed to have medication stored in his rooms unless there was an assessment indicating he was safe to store his medications in his room and there was a physician's order indicating Resident 12 was safe to store his medications in his room. Licensed Staff D also stated Resident 12 should not self-administer medications unless a self-administration assessment had been completed which indicated Resident 12 was safe to self-administer his medications and the physician had ordered that Resident 12 was safe to self-administer his medications. Licensed Staff D stated keeping a medication in Resident 12's room without a proper assessment was a safety risk because they would not know if Resident 12 was taking these medications safely, if Resident 12 could take his medications safely, if Resident 12 knew his medications and what symptoms to report to the nurses. Licensed Staff D also stated it was a safety risk because staff would not be able to monitor for drug-to-drug interactions and side effects. Licensed Staff 12 stated another concern was if a confused resident grabbed Resident 12's medication and ingested it, Licensed Staff D stated this resident could be allergic to it and could suffer adverse effect from the medication. During an interview on 5/23/24 at 12:11 p.m., the Infection Preventionist (IP) stated Resident 12 was not supposed to have medication stored in his room unless there was an assessment and physicians order indicating Resident 12 was safe to store medications in his room. The IP stated Resident 12 was not allowed to self-administer medications unless a self-administration of medications was completed indicating it was safe for him to self-administer medication and a physician order indicating he was safe to self-administer his medications. The IP stated Resident 12 self-administering and storing his OTC medications in his room without a proper assessment and physician order was a safety risk which could result to medication errors, not knowing what side effects to monitor and other confused residents could grab the medications which they could be allergic to and on worst scenario, they could die from. During an interview on 5/24/24 at 9:42 a.m., Licensed Staff E stated she was aware Resident 12 had been bringing in OTC medications from home, was storing his OTC medication in his room and was self-administering his OTC medications. Licensed Staff E stated she was aware there was no assessment completed to indicate Resident 12 was safe to self-administer medication and was safe to store his OTC medications in his room. Licensed Staff E also stated she was aware there was no physician order indicating Resident 12 may self-administer medications and may store his medications in his room. Licensed Staff E stated these were safety issues not only for Resident 12, but also to other residents who might access his medications, ingest it and die from it in extreme cases. A review of the facility's policy and procedure (P&P) titled Self-Administration of Medications revised 12/2013, the P&P indicated .in addition to general evaluation of decision making capacity, the staff and the practitioner will perform a more specific skill assessment including but not limited to ability to read and understand medications labels, comprehension of the purpose and proper dosage and administration time for his or her medications, ability to recognize risks and major adverse consequences of his or her medications .self-administered medications must be stored in a safe and secure place, which is not accessible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 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. 41283 Based on observations and interviews, the facility failed to provide residents with food that was palatable (Palatability may influence food choice as it is proportional to the pleasure someone experiences when eating a particular food. It depends on the sensory properties of the food such as taste, smell, texture, sound, and sight). This failure had the potential to result in nutritional problems if the residents declined to eat the food served by the facility. Findings: During an interview on 5/20/24, at 2:54 p.m., with Resident 12, he stated the food was bad and canned vegetable food that was being served were mushy. He stated the food served had no taste, sometimes served cold. He stated sometimes he did not eat the food provided by the facility. During an interview on 5/20/24, at 3:44 p.m., with Resident 27, he stated the food was not great but did not elaborate what his concerns were with the food served by the facility. During an interview on 5/20/24, time not specified, with Resident 7, she stated she was not getting fresh food. She stated food served was mostly frozen, and pasta dishes. During an interview on 5/20/24, at 3:13 pm., with Resident 18, she stated food served by the facility can be better but did not elaborate on her concerns. During an observation of food preparation on 5/22/24, at 11:45 a.m., at the facility kitchen with the facility RD (Registered Dietitian) and DM (Dietary Manager), it was observed that the main entree was an oven BBQ (Barbecued) beef roast cut into 2 to 3 oz. (ounces) portions, and sides of sauteed zucchini and carrots, and mashed sweet potatoes. After the last food tray was assembled by the dietary staff, a test tray was requested from the RD and the DM. After the last food tray was delivered to a resident by a facility staff and a surveyor, the test tray was served to two surveyors at the facility's conference room. The surveyors found that the zucchini was mushy, and the barbecued beef was very tough in texture. During an interview on 5/22/24, at 4 p.m., with Resident 23, she stated that meat served for lunch was so tough. She stated the texture was like eating leather, and it was so terrible. She stated she could not even cut the meat into small pieces because it was tough to cut into. She stated she only ate the mashed sweet potatoes and the vegetables. During an interview on 5/22/24, at 4:10 p.m., with Resident 7, she stated her meat for lunch was very hard to chew. During an interview on 5/22/24, at 4:20 p.m., with Resident 19, she stated the meat she had during lunch was tough.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 46132 Based on interviews and record reviews, the facility failed to ensure they were electronically submitting Payroll Based Journal (PBJ, a system that facilitate the submission of staffing information) data as required every quarter when the Certification and Survey Provider Enhanced Reporting system (CASPER, an assortment of real-time data that allows skilled nursing facilities (SNFs) the opportunity to pinpoint areas where changes in care and operations are necessary to improve performance) report indicated there was no information for the first quarter (Q1 1/2024 up to 3/2024). Findings: During an interview on 5/22/24 at 10:00 a.m., the Administrator Assistant (AA) stated she did not know how to submit report for PBJ. The AA stated another staff from their sister facility submits the facility's PBJ information to Centers for Medicare and Medicaid Services (CMS, works in partnership with the entire health care community to improve quality, equity and outcomes in the health care system). During an interview on 5/22/24 at 3:04 p.m., the Administrator stated PBJ staffing information should be reported quarterly. The Administrator was unable to provide PBJ information was submitted for the first quarter. The Administrator stated the facility did not have a policy for PBJ reporting. During an interview on 5/23/24 at 9:40 a.m., the Director of Nursing (DON) stated she did not know anything about PBJ and had no idea about PBJ reporting. During an interview on 5/23/24 at 10:11 a.m., the AA stated she assumed PBJ reporting was important to monitor the facility's nursing hours. The AA did not respond when asked what could happen if the nursing hours was not reported to CMS timely. The facility did not have policy and procedure for PBJ reporting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 46132 Based on interview and facility document review, the facility's Quality Assurance and Performance Improvement Program (QAPI, a data driven and proactive approach to quality improvement. It combines two approaches - Quality Assurance (QA) and Performance Improvement (PI). QA is a process used to ensure services are meeting quality standards and assuring care reaches a certain level.) failed to identify quality deficiencies as evidenced by: 1) One sampled resident (Resident 12) self-administered and stored his medications in his room. 2) lack of management oversight that resulted in missing narcotics. There was no investigation or report made to the appropriate agencies until one of the surveyors discovered this deficient practice. 3) lack of protocol and facility's effort to monitor residents and obtain referral and treatment for residents (Resident 1) that were hard of hearing. 4. lack of facility's monitoring and tracking residents that were in need of oral care. 5. lack of monitoring to ensure DHPPD meet the minimum hours required for direct care staffing. 6. lack of Restorative Nursing Assistant (RNA) program for over 2 months. 7. lack of monitoring and tracking of residents (Resident 6) significant weight fluctuations and lack of management oversight on ensuring weight taken were accurate. 8. there were no in services provided for staff regarding baseline care planning (BCP, contain the minimum health care information necessary to care for the residents) and Trauma Informed Care (TIC, an approach care that acknowledges the complete picture of a resident's life situation, past and present, in order to provide effective health care services with a healing orientation and prevent retraumatization). 9) lack of interdisciplinary team's collaboration on ensuring BCP were done thoroughly, completely and timely by the team including the resident or the responsible party (RP, a person who is able to act on behalf of the resident) for Residents 6, 12, 27 and 31. 10A) lack of oversight to ensure residents were offered hand hygiene before and after meals and lack of protocol on where residents should keep their own urinal. 10B) lack of management oversight to ensure there was an effective infection control practice when residents urinal with urine was left at his bedside (Resident 20) or was hung on his walker (Resident 12). The failure to identify these quality deficiencies prevented the QAPI committee from addressing issues and developing corrective plans of actions to mitigate these areas of concern. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/24/24 at 11:18 a.m., the Administrator stated the following issues above were not discussed in QAPI. Findings: 1) During an interview on 5/23/24 at 9:00 a.m., the Director of Nursing stated Resident 12 should not keep any OTC medications in his room. The DON stated the facility did not notify the physician Resident 12 was keeping OTC medications in his room. The DON verified there was no self-administration assessment completed for Resident 12. The DON stated Resident 12 was not allowed to self-administer medications and store medications in his room for safety purposes. 2) During an interview on 5/23 24, the Administrator stated although the DON was aware of the missing narcotics, this deficient practice was not reported to her. There was no investigation done to find out what happened to the missing narcotics and this was not reported to the appropriate agencies as well. 3) During an interview on 5/23/24 at 10:40 a.m., the Social Services Director (SSD)/ Medical Records Director (MRD) verified Resident 1 was HOH. The SSD/ MRD stated Resident 1 had not seen an audiologist as far as she could remember. The SSD/MRD stated as far as Resident 1's HOH was concerned; she does not have anything actively pursuing at this time. The SSD/MRD stated the facility had no protocol on how to address issues when resident was HOH. The SSD/MRD stated in hindsight, Resident 1 could have benefitted if she was referred and seen by an audiologist or be fitted with a functioning HA. The SSD/MRD stated not hearing properly could lead to misunderstanding and not being able to get their concerns addressed. During an interview on 5/23/24 2:22 p.m., the DON stated residents' who were HOH will be offered an audiologist referral. The DON stated that in Resident 1's case, the facility had assumed this was discussed between family and the Administrator. When asked if an audiologist referral was offered to Resident 1, the DON stated not to his knowledge. When asked what the risks could be if a resident was HOH, the DON stated it would be a risk for miscommunication and could lead to resident's frustration. 4) During an interview on 5/21/24 at 1:03 p.m., the Director of Staff Development (DSD) verified Resident 31 had a thick whitish yellowish tinged material on her tongue. The DSD stated this was not acceptable and would have staff provide her oral care now. During an interview on 5/22/24 at 8:25 a.m., the DSD stated staff should provide oral care to the residents at least every shift and as needed. The DSD stated if there were no documentation that an oral care was done, then it meant oral care was not provided for the residents. The DSD stated if oral care was not provided after every meals then residents would be at risk for tooth decay, tooth aches, pain and mouth infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5) for the month of 4/2024, the total direct care service hours patient per day (DHPPD, staffing requirement) was not met for 24 out of 30 days on these dates: 4/1/24, 4/4/24, 4/6/24, 4/7/24, 4/9/24, 4/10/24, 4/11/24, 4/12/24, 4/13/24, 4/14/24, 4/16/24, 4/17/24, 4/118/24, 4/19/24, 4/20/24, 4/21/24, 4/23/24, 4/24/24, 4/25/24, 4/26/24, 4/27/24, 4/28/24, 4/29/24, 4/30/24 and the Certified Nursing Assistant (CNA) PPD was not met for 28 out of 30 days on these dates: 4/1/24, 4/2/24, 4/3/24, 4/4/24, 4/4/24, 4/5/24, 4/6/24, 4/7/24, 4/8/24, 4/10/24, 4/11/24, 4/12/24, 4/14/24, 4/15/24, 4/16/24, 4/17/24, 4/18/24, 4/19/24, 4/20/24, 4/21/24, 4/22/24, 4/23/24, 4/24/24, 4/25/24, 4/26/24, 4/27/24, 4/28/24, 4/29/24, 4/30/24. -for the month of 5/2024, the total DHPPD was not met on 6 out of 20 days on these dates: 5/3/24, 5/4/24, 5/5/24, 5/6/24, 5/12/24, 5/18/24 and CNA PPD was not met on 6 out of 20 days on these dates: 5/4/24, 5/5/24, 5/11/24, 5/12/24, 5/17/24, 5/18/24. During an interview on 5/23/24 at 9:00 a.m., when asked if he was aware the facility was not meeting the minimum requirement for DHPPD, the Director of Nursing (DON) stated I'm sure. The DON stated not meeting the DHPPD meant the facility was short staffed and could put residents at risk for falls and delayed care. 6) During an interview on 5/24/24, at 9:12 a.m., with the Director of Nursing (DON), he stated that the facility did not have the services on an RNA but could not recall for how long. 7) Resident 6 weighed 168.0# indicating a 12.8# or 7.6 % weight loss in 1 month. Further review of Resident 6's weight log indicated that on 9/6/2023, Resident 6 weighed 173.0# and on 5/10/2023, Resident 6 weighed 155.2# indicating a weight gain of 17.8# or 11.5% significant weight gain in 4 months. During an interview on 5/22/24 at 4:11p.m., the Administrator stated a weight variance of 5# should have been reported to the physician and the RD as soon as possible. The Administrator stated it was important to report significant weight variance to the physician and RD to find out what was going on with the resident and to implement plan that would address resident significant weight changes. During an interview on 5/22/24 at 4:45 p.m., the Administrator stated there was a note from RD on 5/24/23 which indicated Resident 6 should be reweighed as the weight taken on 5/10/24 was incorrect. When asked how they knew the weight taken on 5/10/23 was incorrect, the Administrator was silent. The Administrator stated Resident 6 was not reweighed immediately after obtaining an alleged erroneous weight on 5/10/24. The Administrator was not able to find documentation the physician was notified of Resident 6's significant weight changes. The Administrator was not able to find documentation the RD was notified of Resident 6's significant weight gain. 8) During an interview on 5/22/24 at 8:25 a.m., the Director of Staff Development (DSD) stated she was not aware of what BCP was and stated she did not know the timeframe for completing a BCP. However, The DSD stated if a care plan (CP, a form that summarizes a person's health conditions and current treatments for their care) was not completed timely it could lead to residents' not receiving the care they need. The DSD stated it was a safety risk and could compromise residents' health and safety. The DSD stated she was not aware of what a TIC was and had not provided staff any in service about TIC. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9) During an interview on 5/23/24 at 2:37 p.m., the DON stated he was the only one completing the BCP and not the IDT for Residents 12, 27 and 31. The DON also stated the resident, or the responsible party was not involved in developing the BCP for Residents 6, 12, 27 and 31 and the resident or the RP was not provided a copy of the BCP summary for Residents 6, 12, 27 and 31. 10A) During an interview on 5/22/24 at 8:25 a.m., the Director of Staff Development (DSD) stated staff should perform HH before assisting residents with their meals. The DSD stated residents should be offered HH before and after meals per the facility's HH policy. The DSD stated staff were not performing HH before assisting residents with their meals or if staff were not offering HH to residents before and after meals, then the facility was not in compliance. The DSD stated HH was important to ensure there was no cross contamination and for infection control purposes. The DSD stated if residents did not have HH before and after meals, it could lead to residents getting sick with diarrhea or vomiting. 10B) During an interview on 5/23/24 at 12:20 p.m., the Infection Preventionist (IP) stated it was not appropriate to leave a urinal with urine on residents' bedside table or hung on the walker. The IP stated it affects resident's dignity and was a big infection control issue. A review of facility's policy and procedure (P&P) titled Quality Assurance and Performance Improvement (QAPI) Committee, dated 7/2016, the P&P indicated, The primary goals of the QAPI committee were to establish, maintain and oversee facility systems and processes to support the delivery of quality care and services .to promote the consistent use of facility systems and process during provision of care and services . help identify actual and potential negative outcomes relative to resident care and resolve them appropriately .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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** 41283 Based on observations, interviews, and record reviews, the facility failed to ensure that: 1. clean linens were transported from the laundry room to the clean storage areas of the facility by methods that promoted cleanliness and protection from dust and soil, when the linen cart used for the transport was not covered. 2. staff perform hand hygiene (HH, a term used to cover both hand washing using soap and water, and cleaning hands with waterless or alcohol-based hand sanitizers (an alcohol-containing preparation (liquid, gel or foam) designed for application to the hands to inactivate microorganisms and/or temporarily suppress their growth) was being done by staff prior to assisting residents with their meal and staff were offering to the residents HH before and after meals for three out of three sampled residents (Residents 6, 24, and 27) 3. urinals (a vessel for receiving urine) with collection of urine were not hung on resident's walker for one out of two sampled residents (Resident 12), and was not left at his bedside table for one out of two sampled residents (Resident 20). These failures had the potential to result in: 1. contamination of the clean linens and could spread infectious pathogens (Pathogens are microorganisms that have the potential to cause infectious diseases. Viruses, bacteria, protozoans and fungi are all potential pathogens. A pathogen is simply defined as an organism that has the potential to cause infectious diseases in its host) to the residents of the facility. 2. transfer of bacteria and virus resulting to residents getting sick with COVID (a mild to severe respiratory illness that is caused by a coronavirus), GI illnesses (any illness linked to the gastrointestinal system-a collective term referring to the stomach, the small and large intestine), Clostridium Difficile infection (C Diff, a germ that causes diarrhea and colitis (inflammation of the colon) which can be life-threatening), Vomiting (the involuntary, forceful expulsion of the contents of one's stomach through the mouth or nose), and Diarrhea (loose, watery stools three or more times a day). 3. overflow of urine with possible infectious pathogens that could spill on the bedside table or on the floors of different hallways of the facility. Findings: 1. During an observation on 5/23/24, at 2:35 p.m., at a facility hallway, Unlicensed Staff I was observed transporting clean bed linens and clean towels using a laundry cart that had no covers, leaving the clean laundry exposed to dust and soil. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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	During an interview on 5/23/24, at 2:37 p.m., with Unlicensed Staff I, she stated she knew that she had to transport the clean bed linens and towels using a laundry cart that had covers but did not in this instance. A picture of this uncovered cart with clean laundry was taken in the presence of Unlicensed Staff I. During an interview on 5/23/24, at 2:39 p.m., with the facility's IP (Infection Preventionist) nurse, she stated that it was her expectation that clean linens transported from the laundry room to the clean storage rooms in the hallways needed to be covered. During an interview on 5/23/24, at 2:48 p.m., with the Administrator, she stated that Unlicensed Staff I informed her that she just forgot to use the covered clean linen transport cart. A review of a CDC (Centers for Disease Control and Prevention) guidelines on Appendix D- Linen and Laundry Management, dated March 19, 2024, under Best Practices for Handling Clean Linen, indicated, Sort, package, transport, and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens, or other soiled items. 46132 2.A review of Resident 6's face sheet (demographics) indicated he was initially admitted to the facility on [DATE]. His diagnoses included Parkinsonism (a term used to describe the collection of signs and movement symptoms associated with several conditions), Feeding Difficulties (behavioral conditions characterized by severe and persistent disturbance in eating behaviors) and Muscle Weakness.His Minimum Data Sheet Assessment (MDS, a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 2/27/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 3 indicating severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 6's functional status indicated he was dependent on staff assistance during eating. A review of Resident 24's MDS dated [DATE] indicated his diagnoses included Quadriplegia (a symptom of paralysis that affects all a person's limbs and body from the neck down) Cerebral Palsy (CP, a group of movement disorders that can cause problems with posture, manner of walking (gait), muscle tone, and coordination) and Neurogenic Bladder (lack bladder control due to a brain, spinal cord or nerve problem). His MDS dated [DATE] functional status indicated he needed moderate assistance with personal hygiene. His BIMS dated 4/11/24 score was 15 indicating intact cognition. A review of Resident 27's face sheet indicated his admitted was 2/3/24. Resident 27's diagnoses included Muscle Weakness, Dysphagia (difficulty swallowing) and HTN. His BIMS dated 5/9/24 indicated severe cognitive impairment. His MDS dated [DATE] functional status indicated he was dependent on staff for provision of care. During an observation on 5/21/24 at 12:20 p.m., no HH was offered by Unlicensed Staff F to Resident 27 prior to him eating his lunch. During an observation on 5/21/24 at 12:27 p.m. Unlicensed Staff H shook Resident 6's hand. No HH performed by Unlicensed Staff H prior to assisting Resident 6 with his lunch. Resident 6 was not offered HH by Unlicensed Staff H prior to eating his lunch. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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	During an interview on 5/21/24 at 12:33 p.m., Resident 24 stated staff were not consistent in performing HH and did not consistently offer HH to residents before and after meals. Resident 24 stated he was not offered HH before his lunch. During an interview on 5/22/24 at 8:25 a.m., the Director of Staff Development (DSD) stated staff should perform HH before assisting residents with their meals. The DSD stated residents should be offered HH before and after meals per the facility's HH policy. The DSD stated staff were not performing HH before assisting residents with their meals or if staff were not offering HH to residents before and after meals, then the facility was not in compliance. The DSD stated HH was important to ensure there was no cross contamination and for infection control purposes. The DSD stated if residents did not have HH before and after meals, it could lead to residents getting sick with diarrhea or vomiting. During an interview on 5/22/24 at 8:56 a.m., Unlicensed Staff F stated residents should be offered or provided with HH before and after meals, so they do not get sick such as diarrhea. During an interview on 5/22/24 at 4:35 p.m., Licensed Staff G stated residents should be offered or assisted with HH before and after meals for infection control purposes, to prevent cross contamination and to prevent spread of bacteria. Licensed Staff G stated if HH was not offered to the residents before and after meals, residents could be at risk for COVID and GI illnesses like C diff and diarrhea. During an interview on 5/22/24 at 4:45 p.m., the IP stated staff should offer or assist residents with HH before and after meals per facility policy to prevent infection and cross contamination. The IP stated if the HH was not done before and after meals, the facility policy was not followed. The IP stated HH was important before and after meals to prevent residents from contracting GI illnesses. The facility's policy and procedure for HH was requested but was not provided. 3. A review of Resident 12's face sheet (demographics) indicated he was initially admitted to the facility on [DATE]. His diagnoses included Hyperlipidemia (HLP, high cholesterol is an excess of lipids or fats in your blood), Essential Hypertension (HTN, high blood pressure) and Muscle Weakness. His Minimum Data Sheet Assessment (MDS, a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 2/25/24 indicated Resident 12 needed up to maximum assistance when performing his ADL. Resident 12 was dependent on staff with lower body dressing and when putting on or taking off his shoes. His Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score dated 2/23/24 score was 14 indicating intact cognition. A review of Resident 20's face sheet indicated his admitted was 3/1/24. His diagnoses included Muscle Weakness, Compartment Syndrome (a painful condition that occurs when pressure within the muscles builds to dangerous levels) and Seizures (sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain. His MDS dated [DATE] functional status indicated he needed up to maximal assistance when performing his ADLs and was dependent on staff when putting on or taking off his shoes. His BIMS score dated 3/3/24 was 3 indicating intact cognition indicating severely impaired cognition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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	During a concurrent observation and interview on 5/20/24 at 3:12 p.m., Resident 12 had two urinals, filled with about one fourth (1/4, one of four equal parts) of yellow tinged liquid hung on his walker. Resident 12 stated the yellow tinged liquid was his urine. During a concurrent observation and interview on 5/22/24 at 12:54 p.m., Resident 20's urinal which was filled about 1/4 of yellow tinged liquid was kept at his bedside table. Resident 20 stated the yellow tinged liquid in his urinal was his urine. During an interview on 5/23/24 at 10:53 a.m., Unlicensed Staff H stated it was not appropriate to leave a urinal with urine on residents' bedside or hung at the resident's walker for dignity and infection control. During an interview on 05/23/24 at 10:58 a.m., Unlicensed Staff F stated it was not acceptable to hung urinal with urine on the resident's walker or at the bedside table for dignity and infection control purposes. During an interview on 5/23/24 at 11:02 a.m., the Director of Staff Development (DSD) stated it was not acceptable to hang a urinal on residents' walker and at the bedside table for safety purposes due to risk for spillage which could result in falls and accidents. The DSD stated it was not acceptable to hang a urinal on residents' walker and at the bedside table because it affects residents' dignity and for infection control purpose. During an interview on 5/23/24 at 11:06 a.m., Licensed staff D stated it was not appropriate to leave a urinal with urine at residents' bedside or hung on the residents' walker. Licensed Staff D stated it affects residents' dignity and was a big infection control issue. During an interview on 5/23/24 at 11:58 a.m., the Activity Director (AD) stated it was not appropriate to keep a residents' urinal with urine at his bedside table or and hung on the walker. The AD stated it was an infection control issue and a dignity issue. The AD stated residents should have a dignified existence. During an interview on 5/23/24 at 12:20 p.m., the Infection Preventionist (IP) stated it was not appropriate to leave a urinal with urine on residents' bedside table or hung on the walker. The IP stated it affects resident's dignity and was a big infection control issue. During an interview on 5/23/24 at 2:22 p.m., the Director of Nursing (DON) stated it was not acceptable to keep a urinal with urine at residents' bedside or hung on the walker. The DON stated this was a dignity issue and a big infection control issue. There was no care plan (CP, a form that summarizes a person's health conditions and current treatments for their care) to indicate Resident 6 was requesting to keep his urinal at his bedside table or Resident 12 requesting to keep his urinal hung on his walker. A review of the facility's policy and procedure (P&P) titled Bedpan/Urinal, Offering/Removing, revised 2/2018, the P&P indicated if the resident prefers to keep a urinal at his bedside, check it frequently, empty and clean as necessary .note on resident's care plan his request to keep his urinal at his bedside.