STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555153	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Oaks Healthcare Center	11300 Fair Oaks Blvd. Fair Oaks, CA 95628

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate foot care. 47563 Based on interview and record review, the facility failed to ensure one resident (Resident 1) out of three sampled residents received proper foot care when: 1. Lack of documentation indicating Resident 1's wound on the right foot second toe was being assessed per nursing standards; and 2. Transportation services were not provided to Resident 1's podiatry (the medical care and treatment of the human foot) appointments. These failures resulted in Resident 1 not receiving foot care per nursing standards which led to a partial right foot amputation (surgical removal of part of the body). Findings: A review of Resident 1's face sheet, dated 3/1/24, indicated Resident 1 was admitted to the facility [EC1] on 11/11/20 with diagnoses which included peripheral vascular disease (PVD, a narrowing of a blood vessel which decreases circulation of blood to a body part), diabetes (DM 2, a chronic condition that affects the way the body processes blood sugar, which slows the body's ability to heal wounds), heart failure (CHF, when the heart does not pump blood efficiently throughout the body), peripheral neuropathy (nerve damage that can cause weakness, numbness, and pain that usually affects the hands and feet), history of diabetic foot ulcer (wound on foot that develops in people with diabetes), osteomyelitis (swelling caused by infection of the bone) and partial left foot amputation. A review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 11/23/23, indicated resident had no memory impairments. A review of Resident 1's care plan, created on 12/3/20 and edited on 11/27/23, indicated, Problem .Self care deficit r/t [related to] h/o [history of] osteomyelitis[EC2] of [left] foot with partial foot amputation, PVD, DM 2 with peripheral neuropathy[EC3] , CHF .Goal .Resident will be able to function at the highest possible level as evidenced by X [times] 3months [EC4] [sic] .Approach .[nurses will] Shower/Bathe two times each week as scheduled . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0687 Level of Harm - Actual harm Residents Affected - Few	A review of an electronic mail (e-mail), dated 10/9/23 at 11:51 a.m., indicated Resident 1 had an appointment with his Podiatrist (a medical professional who specializes in the treatment of disorders of the foot, ankle, and related structures of the leg) on 10/11/23 at 11 a.m. Resident 1 missed the appointment and there was no documented reason. A review of an e-mail, dated 11/3/23 at 1:22 p.m., indicated Resident 1 had an appointment with his Podiatrist on 11/7/23 at 11:10 a.m. Resident 1 missed the appointment and there was no documented reason. A review of Resident 1's care plan, edited 11/27/20 and on 11/27/23, indicated, Problem .At risk for impaired skin integrity r/t .decreased sensation to BLE [both lower extremities] hitting .against bed/bedside table and is unaware of the incident .[h/o] left partial foot amputation .Approach .Licensed nurse to assess resident skin head to toe weekly .Monitor feet/heels for s/s [EC5] [signs and symptoms] of skin breakdown, poor circulation such as redness, dry skin and/or open area. Notify MD[EC6] [medical doctor] if found .Observe skin for s/s of skin breakdown .Podiatry as ordered .Wound consultant as needed . A review of Resident 1's order summary report indicated, .[Starting on 12/4/23, nurses were to] Dry scab to right 2nd toe .leave area open to air. Monitor area daily. Every day shift . This order summary report also indicated an order for, Podiatry for skin/nail problem conditions .order date 12/23/23. A review of a nurse progress note dated 12/24/23 at 12:45 p.m. indicated, [Resident 1] was taking off his [Left] leg/foot brace [with] right foot and upon doing so tore right second toe ulcer scab and started bleeding, cleaned .wrapped [with gauze], Treatment nurse made aware of incident. A review of Resident 1's Orders- Administration Note, written by the Treatment Nurse 2 (TN 2), dated 1/11/24 at 1:46 p.m., indicated, Dry scab to right 2nd toe . leave open to air. Monitor area daily. Every day shift. Scab re-opened; covered with bandaid, MD notified A review of Resident 1's SNF [Skilled Nursing Facility] Custodial Visit , dated 1/30/24, by Resident 1's Primary Care Physician (PCP), indicated no documented evidence Resident 1's right foot had been assessed.[EC7] [VAE8] A review of Resident 1's SNF Visit and Generalized Body Pains note written by the Nurse Practitioner 1 (NP 1), dated 2/9/24 for a visit conducted on 2/8/24, indicated, [Resident 1] tells me he feels 'achy' and didn't want to eat much this morning .last saw [Podiatrist] 9/28/23, was to follow up in one month? Was a now [sic] show for podiatry appts in October, Nov, December .Extremities- has dry scab on right foot second toe, old healed scabs from scratching on legs .2/9/24 labs now show WBC [white blood cell count] 19.2 [expected range 5-10] .DM 2 [with] ULCER OF RIGHT FOOT Unchanged, not sure why patient was no show will message [nurse] to call SNF with appointment . A review of a nurse progress note dated 2/10/24 at 2:07 p.m. indicated, [Resident 1] on [oral antibiotic for] foot infection .foot has scabbed. [Resident 1] encouraged not to pick at scabs .will continue to monitor. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	A review of a weekly wound observation tool, dated 2/12/24 at 4:50 p.m., indicated, .Wound type .Diabetic ulcer .Describe other .Probably moisture-related .Present upon admission .No .What date wound was identified .2/12/24 .Length .1.3 cm [centimeters, a unit of measurement] .Width .1.5 [cm] .Depth .0.2 [cm] . Exudate [fluid that leaks out of blood vessels into nearby tissues which may ooze from cuts or from areas of infection] .Moderate .Exudate Type .Serosanguineous[EC9] [thin, watery, pale, red/pink drainage] [and] purulent [containing pus] thick, opaque [cannot see through], tan/yellow drainage .Wound Stage .Stage 3: full thickness skin loss .Describe Wound Edge/Margin .Erythema[EC10] : [Redness of the skin] .Unable to fully visualize wound bed due to location. Wound edges are erythematous [abnormal redness of the skin] A review of a skin/wound note, dated 2/12/24 at 4:55 p.m., indicated, [Resident 1] is not sure how injury occurred. He has a [history] of diabetic neuropathy [nerve damage caused by diabetes that can cause weakness, numbness and pain that usually affects the hands and feet] [EC11] and has frequent injuries to bilateral lower extremities that he cannot recall. Spoke with [staff] at [Podiatrist's] office .who states [Resident 1] has missed several recent appts over the last few months but has scheduled appt with wound care this Fri. , 2/16. Office informed of new wound and states a message will be sent to [Podiatrist] in the meantime .[NP 1] informed .[NP 1] will photograph wound in [morning] . A review of telephone encounter note from Podiatrist 1 (PD 1), dated 2/13/24, indicated, .it does appear that [Resident 1] has missed several appts [appointments]-both with preventative RN staff AND me over past year . [NP 1] to assess for the infection . if there is infection, patient should be seen in [emergency room] . A review of a SNF Transfer and Toe Problem note, dated 2/13/24 at 4:10 p.m., indicated, . [Resident 1] toes had multiple scabs but today his right foot second toe is edematous, macerated[EC12] [softening and breaking down of skin resulting from prolonged exposure to moisture] with what looks like necrotic tissue [dead tissue] between, the toes .Transfer to ED [Emergency Department] for further evaluation, high risk patient . A review of a nurse progress note dated 2/13/24 at 5:01 p.m. indicated, Received orders to send [Resident 1] to hospital to r/o [rule out] sepsis[EC13] [a severe response to infection which can lead to organ damage] r/t [related to] second toe wound. A review of Resident 1's skilled nursing facility discharge summary, dated 2/13/24, indicated, . [Resident 1] is a long term care patient . after . left midfoot amputation .today his right foot second toe is edematous, macerated with what looks like necrotic tissue between the toes .transfer to ED for further evaluation, high risk patient . A review of Resident 1's hospital ED treatment note, dated 2/13/24, indicated, [Resident 1] .present with concerns for an ulcer between his right toe .there is some necrotic tissue along the lateral aspect [the side] [EC14] of the second toe with ulceration [break in skin] . A review of Resident 1's hospital podiatry consult note, dated 2/14/24, indicated, [Resident 1] .Patient present with ongoing swelling, infection to the right lower extremity second digit[EC15] [toe or finger]. Positive probe to bone, indicative of osteomyelitis .Podiatry team will plan for right foot second digital amputation on 2/14/24 . (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's hospital discharge summary, dated 2/29/24, indicated, .hospital course and significant findings .admitted with diabetic ulcer right foot, s/p [status post] TMA [transmetatarsal amputation[EC16] : surgery to remove part of foot] [2/24/24] . In an interview on 3/1/24 at 9:10 a.m., the Executive Director (ADM) stated the facility's Social Services Coordinator (SSC) was expected to arrange transportation services to outside appointments, such as podiatry appointments, for long term residents. In an interview on 3/1/24 at 12:27 p.m., Resident 1 stated the facility was supposed to set-up transportation to his podiatry appointments and he was aware he had missed at least one podiatry appointment. Resident 1 stated staff did not explain why he had missed his podiatry appointments. Resident 1 confirmed he developed a wound on his right foot in December of 2023. Resident 1 stated he felt safe in the facility but was upset and felt the care of his foot had not been prioritized. In an interview on 3/1/24 at 1:25 p.m., Licensed Nurse 1 (LN 1) stated she cares for residents who have wounds by reviewing the documented history of the wound(s) and carefully reading the treatment administration record. In an interview on 3/1/24 at 1:35 p.m., Certified Nursing Assistant 2 (CNA[EC17] 2) stated if staff did not monitor skin issues, then open wounds could become infected and can affect the bone which can change the way a resident can function. The CNA 2 added the infection could be painful and cause the resident to not want to eat. In an interview on 3/1/24 at 1:50 p.m., Treatment Nurse 1 (TN 1) confirmed she worked at the facility as a dedicated treatment nurse. As a treatment nurse, TN 1 stated she attended weekly wound meetings with the Assistant Director of Nursing (ADON) to discuss concerning wounds. The TN 1 stated she was expected to conduct and document weekly assessments of resident wounds. In an interview and concurrent record review on 3/1/24 at 2:37 p.m., the ADON stated a wound that was persistent for two months would have been discussed in the weekly wound meeting which consisted of the ADON, the unit manager, treatment nurses, and a dietician. The ADON also stated she expected persistent wounds to be documented at least weekly to determine if it was improving or worsening. The ADON stated she believed Resident 1's dry scab on the right second toe had healed but was unable to provide documentation the wound had resolved. The ADON stated she could not recall discussing Resident 1's wound in any of the weekly wound meetings or interdisciplinary team meetings and verified Resident 1's medical chart showed no documented evidence of such discussions between December 2023 and February 2024. The ADON acknowledged, based on documentation available, the wound on Resident 1's right second toe had been present from December 2023 to February 2024. The ADON stated transportation for outside appointments were arranged by the social services department. The ADON further stated if there is no documentation in the resident's chart, then it was not done. In an interview on 3/1/24 at 3:30 p.m., the Social Services Director (SSD) stated the social services department arranged transportation to outside appointments when the nurse notified them of the resident's appointment. The Social Service Coordinator (SSC) then communicates to the nursing unit of the confirmed transportation. The SSD stated the unit nurses were responsible for getting the resident up and ready for transportation. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	In an interview on 3/1/24 at 3:40 p.m., the SSC confirmed she arranged for transportation for Resident 1's podiatry appointments. The SSC stated she was first made aware of Resident 1's missed podiatry appointments in early February of 2024 by the NP 1. The SSC stated the last podiatry appointment transportation she arranged for Resident 1 was in November 2023. In an interview on 3/20/24 at 9:18 a.m., the SSC stated there was a failure in communication which led to Resident 1's missed podiatry appointments. In an interview on 3/20/24 at 9:55 a.m., LN 2 stated a resident with diagnoses of PVD and DM 2 would have a risk of developing wounds and added vascular and diabetic ulcers are difficult to treat and heal. The LN 2 stated he expected each wound to have a care plan which included monitoring and documentation of the monitoring. The LN 2 further stated measurements of the wound needed to be documented to determine its progress. An interview on 3/20/24 at 10:20 a.m., TN 2 accessed Resident 1's medical records on her computer. The TN 2 stated she had been monitoring Resident 1 for a non-healing scab since December 2023. The TN 2 stated she monitored the wound by looking at it and would report to physician if she felt there was a change to the wound that needed to be addressed. When asked how she would know if the wound was changing, she replied because I look at it and know. When asked if there was any documentation indicating descriptions of the size or changes to the wound on the right second toe before 2/12/24, she confirmed there was not. When asked if it was a concern that Resident 1 had a wound on his foot from December to February, the TN 2 replied, it's a gray area . I was monitoring a dry scab . something that is not concerning. When asked how she would know if the wound was improving, the TN 2 disclosed, I was not monitoring that closely and alleged she was not aware of the right second toe lateral wound until 2/12/24 and added, it was hard to see. The TN 2 confirmed she knew having a diagnosis of DM2 and PVD were high risk factors for poor wound healing, but she had not notified NP 1 about Resident 1's right second toe wound until 2/12/24. The TN 2 added, Resident 1 had always had a podiatrist due to his other foot issues and expected he was getting podiatry services. In an interview and concurrent record review on 3/20/24 at 11:16 a.m., in the Director of Nursing (DON) office, the DON stated residents with diagnoses of DM2 and PVD would be at high risk for developing wounds and poor wound healing. The DON stated she expected nurses to monitor wounds, document descriptions of wounds and notify the physician of any changes. The DON added she expected the physician to be notified if the wound was not responding/healing within two weeks and added, we need to do something else. The DON stated if a resident had a wound on the foot that was not healing the physician would refer the resident to a podiatry specialist. The DON accessed Resident 1's medical records on her computer, confirmed she could read Resident 1's progress notes and assessments since December 2023. The DON confirmed the progress note written on 12/24/23 which indicated Resident 1 had a wound on his right second toe without any further descriptors such as size, presence of exudate or necrotic tissue. The DON also confirmed the progress note written on 1/11/24 which indicated Resident 1 had a scab reopen on right second toe but also had no other descriptions of the wound. The DON continued to search Resident 1's medical records and confirmed she could not find any documentation that clearly described Resident 1's wound on his right second toe until 2/12/24. The DON acknowledged, without descriptions of the wound documented, it would not be possible for staff to know if the wound was improving. The DON reiterated a wound that does not improve should always be a concern. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	In an interview on 3/20/24 at 1:20 p.m., the NP 1 stated she was aware Resident 1 had a history of wounds on his right foot and a partial left foot amputation. The NP 1 stated she discovered in early February 2024 Resident 1 had missed his podiatry appointments (in October, November, and December of 2023) that she documented in a progress note. When asked if it was a concern for Resident 1 to miss podiatry appointments, the NP 1 stated, Of course it is a concern. The NP 1 added Resident 1 was at high risk for infection and losing toes due to his DM2 and concluded, If [Resident 1] wasn't high risk he wouldn't be seeing the podiatrist. The NP 1 confirmed she evaluated Resident 1's right foot on 2/13/24 and determined he should be sent to the hospital for further evaluation and treatment of suspected infection to right foot. A review of the facility's policy and procedure titled, Prevention of Pressure Injuries, revised April 2020, indicated, .Skin Assessment .During the skin assessment, inspect .presence of erythema .Temperature of skin and soft tissue .edema[EC18] [swelling cause by trapped fluid] .inspect the skin on a daily basis .identify . darkly pigmented skin, inspect for changes in skin tone, temperature and consistency .Monitoring [expectations] .Evaluate, report and document potential changes in the skin .Review the interventions and strategies for effectiveness on an ongoing basis. A review of the facility's policy and procedure titled, Pressure Ulcers/Skin Breakdown- Clinical Protocol, revised April 2018, indicated, .nurse shall describe and document/report the following .full assessment of pressure sore [area of damage to skin and underlying tissue caused by pressure] [EC19] including location, stage, length, width and depths, presence of exudate or necrotic tissue .Monitoring [expectations] .During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or poorly-healing wounds .The physician will guide the care plan as appropriate, especially when the wounds are not healing as anticipated . A review of the facility's policy and procedure titled, Transportation, Social Services, revised December 2008, indicated, Our facility shall help arrange transportation for residents as needed .social services will help the resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47563 Based on observation, interview, and record review, the facility failed to maintain an effective infection prevention program for one resident (Resident 1) out of three sampled residents, when the Treatment Nurse 1 (TN 1): did not clean bandage scissors prior to or after cutting a soiled wound dressing, placed treatment supplies directly on Resident 1's bed and returned supplies to the treatment cart, and did not perform hand hygiene (simple act of cleaning hands to present the spread of germs) during a wound treatment. These failures increased the risk for cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another) and the potential for infection. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses which included peripheral vascular disease (PVD: a narrowing of a blood vessel which decreases circulation of blood to a body part) and diabetes (DM2: a chronic condition that affects the way the body processes blood sugar, which slows the body's ability to heal wounds). A concurrent observation and interview on 3/1/24 at 2:10 p.m., with TN 1 during Resident 1's right foot surgical site bandage change. TN 1 placed a plastic bin of treatment supplies and a box of disposable gloves directly on Resident 1's bed and put on a pair of gloves without performing hand hygiene. TN 1 removed a pair of bandage scissors from a pouch on her belt, without cleaning them, cut off Resident 1's old bandages, that had reddish/brown stains, from Resident 1's right foot surgical wound and placed bandage scissors directly on Resident 1's bed. With gloved hand TN 1 removed old bandages from Resident 1's right foot. After removing soiled bandages, TN 1 without changing gloves or performing hand hygiene, picked up a cup with bandages soaking in a reddish brown liquid and stated she was going to apply [povidone-iodine] (a topical antiseptic used to treat and prevent infection) to Resident 1's surgical wound. For resident safety the bandage change was stopped and TN 1 was asked to go to the hallway. In the hallway outside of Resident 1's room, TN 1 acknowledged she had not changed her gloves, nor planned to change gloves, after removing the soiled bandages and prior to applying [povidone-iodine] and added she had not touched the dirty parts of the old dressing with gloves. Upon returning to resume Resident 1's right foot bandage change, TN 1 put on a new pair of gloves without performing hand hygiene and applied [povidone-iodine] to Resident 1's right foot surgical wound. TN 1 then removed gloves, did not perform hand hygiene, put on a new pair of gloves, and continued to wrap Resident 1's surgical wound with bandages. After rebandaging Resident 1's surgical wound, TN 1 exited Resident 1's room, put the used bandage scissors, without cleaning them, back in the pouch on her belt, placed the plastic bin of supplies and the box of disposable gloves on top of the treatment cart and stated she had completed all steps she needed to perform. TN 1 acknowledged she had placed the plastic bin of supplies, box of disposable gloves, and bandage scissors on Resident 1's bed during the bandage change and denied concerns for infection control. TN 1 acknowledged she had not performed hand hygiene after removing soiled gloves and prior to putting on new gloves and added she had not been taught to perform hand hygiene between glove changes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 3/1/24 at 2:37 p.m., the Assistant Director of Nursing (ADON) stated she expected Treatment Nurses to follow infection control practices by putting treatment supplies and gloves on clean and sanitary surfaces, cleaning bandage scissors prior to and after being used for wound treatments, performing hand hygiene prior to putting on clean gloves, and changing gloves after removing a soiled bandage and prior to applying [povidone-iodine] to a surgical wound. The ADON added, if these infection control practices were not followed, she would be concerned with cross contamination that would put residents at risk for infections. An interview on 3/7/24 at 3:56 p.m., the Director of Staff Development (DSD) stated she expected nurses to ensure a sanitary barrier between wound treatment supplies and potentially contaminated surfaces. The DSD added, supplies that touched the resident bedding would be contaminated and could lead to spreading infection. The DSD stated she expected nurses to change gloves after removing a soiled bandage and prior to cleaning a surgical wound. The DSD stated she also expected nurses to perform hand hygiene after removing soiled gloves and prior to putting on clean gloves. The DSD stated used bandage scissors that were put away without being cleaned would have been a risk for cross contamination that could also lead to spreading infection. A review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, revised August 2019, indicated, This facility considers hand hygiene the primary means to prevent the spread of infections .all personnel shall be trained and regularly in-serviced on the importance of hand hygiene in prevention the transmission of healthcare-associated infections .all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections .Use an alcohol-based hand rub . or, alternatively, soap . and water for the following situations: .before and after direct contact with residents .before handling clean or soiled dressings, gauze pads, etc. before moving from a contaminated body site to a clean body site during resident care .after handling used dressings . after removing gloves . the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections . A review of the Centers for Disease Control and Prevention's (CDC: a service organization that protects the public's health) document titled, Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPC) Across Settings, dated 1/27/23, indicated, .maintain separation between clean and soiled equipment to prevent cross contamination .Wound care supplies such as dressing materials and equipment . should be brought into the patient/resident's room or treatment area and placed on a clean surface and away from potential sources of contamination . Any unused disposable supplies that enter the patient/resident's care area should remain dedicated to that patient/resident or be discarded. They should not be returned to the clean supply area . To prevent pathogen transmission, reusable wound care equipment should be cleaned and disinfected after each use . reusable equipment should also be transported and stored in a manner to prevent contamination when moved between treatment areas. For example, bandage scissors should not be carried in pockets .

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 47563 Based on interview and record review, the facility failed to ensure an Infection Preventionist (IP: a nurse responsible for the facility's Infection Prevention and Control Plan) was available to meet all the requirements of the position for a census of 141 residents. This failure decreased the facility's potential to prevent the spread of infection among staff and residents. Findings: An interview on 3/1/24 at 9:10 a.m., the Executive Director (ADM) stated the facility's full time IP left in January 2024 and indicated the IP continued to work part-time during February 2024. The ADM added, the facility was hoping to hire a full time IP soon. An interview on 3/1/24 at 2:37 p.m., the Assistant Director of Nursing (ADON) stated the facility is in between IPs and was unable to confirm the facility had anyone working in the IP role. An interview and concurrent record review on 3/1/24 at 4:30 p.m., the ADM provided time sheets for the facility's IP. The time sheet for dates 2/1/24-2/15/24, indicated the IP had worked zero hours. Additionally, there was no time sheet provided for the dates 2/16/24-2/29/24 as requested. The ADM stated there were no February hours on the February time sheets yet due to being the beginning of the month. The ADM stated he would email the Department the IP's updated February time sheets by 3/6/24. The facility did not send the Department any further time sheets for the facility's IP. An interview and concurrent record review on 3/20/24 at 9:05 a.m., the ADM stated there was not an IP at the facility's quarterly Quality Assurance (QA) meeting that was held on 1/25/24. The ADM provided a copy of the 1/25/24 QA meeting sign-in sheet that indicated the facility had no IP in attendance. An interview on 3/20/24 at 11:13 a.m., the ADM acknowledged he could not provide further time sheets for the facility's IP and confirmed the IP had not worked any hours in February 2024. An interview on 3/20/24 at 11:16 a.m., the Director of Nursing (DON) stated it is important to have an IP that works in the building and acknowledged the IP is expected to be present at facility's quarterly QA meetings. An interview on 3/20/24 at 12:08 p.m., the Resource Nurse Consultant (RNC) indicated the facility's Director of Staff Development (DSD) was certified as an IP and had been performing the IP duties. The RNC stated would provide the DSD's IP certification and documentation indicating what work the DSD had performed as the IP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555153	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Oaks Healthcare Center	11300 Fair Oaks Blvd. Fair Oaks, CA 95628

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 3/20/24 at 1 p.m., the ADM confirmed the DSD was not performing the duties of the IP role. An interview on 3/20/24 at 1:02 p.m., the RNC confirmed the DSD was not certified to perform the role of an IP and was not acting as the facility's IP. A review of the facility's policy and procedure titled, Infection Prevention and Control Program, revised October 2018, indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .The infection prevention and control program . is an integral part of the quality assurance and performance improvement program . The infection prevention and control program is coordinated and overseen by an infection prevention specialist (infection preventionist) . The committee meets regularly, at least quarterly .