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	07/16/2024

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

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 32096 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1's) rights were exercised timely when the facility discontinued an antipsychotic medication (used for treating psychosis or disconnection from reality) for Resident 1 without notifying the resident's representative (RR). This failure resulted in Resident 1's family members being frustrated and baffled by the resident's change in behaviors. Findings: Review of Resident 1's medical record, Admission Record , indicated Resident 1 was a long term resident in the facility with diagnoses that included memory problem with agitation, anxiety disorder and legal blindness. In the Admission Record, three family members were listed as the emergency contacts, one of them being the RR for Resident 1. In a telephone interview on 7/15/24 at 1:36 p.m., Resident 1's family member stated that the facility discontinued Seroquel, an antipsychotic medication, that had worked well for the resident without notifying the RR or any of the resident's family members. He stated the resident changed in behaviors in the absence of Seroquel administration: screaming to the extent of losing her voice and refused to listen to him when he visited the resident. The family member stated he was frustrated and did not understand why the resident changed in behaviors until the facility contacted him when they reinstated Seroquel back to the resident in June. The family member stated Seroquel had worked well for the resident and indicated the discontinuation of the medication caused the resident's screaming behavior. He voiced that had the facility notified the discontinuation of Seroquel, the family would not have consented because the medication had been working fine for the resident. Review of Resident 1's medical record, Physician Order History , indicated Seroquel was discontinued on 4/23/25 and reinstated 6/25/24, with the target behavior for yelling and screaming out loud. There was no documented evidence in the medical record that Resident 1's RR and/or family member was notified when Seroquel administration was stopped. (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
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/16/24 at 10:18 a.m. in the hallway, Licensed Nurse (LN 1) stated Resident 1 had behaviors of yelling and screaming and stated the resident did not stop screaming until she got tired. LN 1 stated Resident 1 was really screaming and staff were unable to stop the resident when she started to scream. LN 1 indicated Resident 1 had a medication for the behavior and stated when the resident took the medication, the resident was fine. Review of the facility's revised 2/2021 policy and procedure, Change in a Resident's Condition or Status , stipulated, Our facility promptly notifies the resident .and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care .resident rights, etc.). In a concurrent interview and record review on 7/16/24 at 1:36 p.m., in the foyer of the facility, the Director of Nursing (DON) stated it was the facility policy to notify RR when there was change in resident's care. The DON explained this included resident's change in medications either discontinuation or reinstatement of the medication. The DON stated Resident 1's RR should have been notified when Seroquel was discontinued. In a telephone interview on 7/16/24 at 3:27 p.m., Resident 1's RR expressed the same concerns as the family member who reported over the phone on 7/14/24 regarding the resident's behaviors and medications and stated she was not aware that Seroquel had been discontinued because the facility did not notify her.