

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Fair Oaks Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. 38834 Based on interview and record review, the facility failed to provide nursing services in accordance with professional standards of practice to meet the needs of one of four sampled residents (Resident 1), when the facility did not follow a physician order to perform laboratory blood tests. This failure had the potential to result in worsening of Resident 1 ' s bladder infection and subsequent need to transfer to a hospital. Findings: A review of the facility ' s policy titled, Request for Diagnostic Services, with the last revision date of 2007, indicated, All orders for diagnostic services must be entered into the resident ' s medical record .Orders for diagnostic services will be promptly carried out as instructed by physician ' s order .Emergency requests must be labeled stat [now] to assure that prompt action is taken. A review of Resident 1 ' s admission record indicated the facility admitted the resident in 2023 with multiple diagnoses which included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control), lung and heart diseases. A review of Resident 1 ' s clinical records contained a document SBAR notification (Situation, Background, Assessment, and Recommendations - a document to communicate with physician) dated 12/16/24 which indicated that the resident had been diagnosed with dehydration (a condition that occurs when the body loses too much water) and urinary tract infection (UTI, a bladder infection). Resident 1 ' s clinical records indicated the resident was prescribed treatment with antibiotics (medications to treat the infection). A review of the nursing progress notes dated 12/26/24, at 1:10 p.m., indicated that Resident 1 was very sleepy and refused to get up. The nurse documented that the resident ' s family were concerned that something was wrong with [Resident 1]. The nurse documented that the physician was notified, and the physician ordered two blood tests. A review of Resident 1 ' s physician order dated 12/26/24, at 1.08 p.m., contained a physician order for two blood tests. One of the ordered tests was to evaluate if the resident responded to treatment for UTI or if she still had the bladder infection. According to physician order, both blood tests were ordered to be completed STAT (a medical term that means immediately, without delay). (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility document titled, Patient Service Log dated 12/27/24 contained name of three residents, including Resident 1 ' s name. The left side of the document contained residents ' names and the blood tests that were to be done for the residents. The right side of the document indicated the dates the tests were performed. Resident 1 ' s blood tests had no documentation if they were completed, cancelled, or rescheduled. A review of Resident 1 ' s clinical record indicated there was no documented evidence the ordered blood tests were carried out on 12/26/24 or at a later date. Resident 1 ' s medical records contained no results of blood tests ordered on 12/26/24. A review of the clinical records contained SBAR notification dated 12/30/24, at 12:52 p.m., indicating that Resident 1 was experiencing a change of condition. The nurse documented that the resident had altered level of consciousness (a change of awareness and alertness, manifested by confusion, disorientation, and lethargy). Resident 1 ' s records indicated that the resident was sent to emergency department for further evaluation. A review of Resident 1 ' s hospital records dated 12/30/24 contained a diagnosis of, Acute encephalopathy [a serious neurological disorder of altered brain function] secondary to acute urinary infection. Per hospital records Resident 1 received treatment with multiple antibiotics and was hospitalized for 9 days. During an interview on 1/8/25, at 4 p.m., Licensed Nurse (LN 1) explained that if the blood test was ordered STAT, the nurse had to enter the order into computer immediately to notify the laboratory and follow up with a phone call to make sure the laboratory was aware the test(s) must be done without delay. During an interview on 1/8/25, at 4:25 p.m., LN 2 stated the STAT order means right away, immediately and added that the staff had to follow up with the laboratory to inform them of STAT blood tests. LN 2 stated that the physician had to be notified right away if the resident refused the blood tests and the test was not completed. During an interview with the Infection Control Nurse (ICN) on 1/8/25, at 4:50 p.m., the ICN validated that Resident 1 was hospitalized for UTI after she was treated for the same infection in the facility. The ICN was asked how the facility assured that the antibiotic treatment was effective and the resident no longer had the infection. The ICN stated that sometimes the physician would order another urine test after the treatment was completed. The ICN stated that Resident 1 had blood tests ordered on 12/26/24 after the resident had completed her treatment for UTI but had no follow up urine test ordered. The ICN was unable to find the results of the tests ordered on 12/26/24 and mentioned that the results might not have been uploaded into resident ' s electronic chart yet. During a telephone interview on 1/9/25, at 4:43 p.m., the Director of Nursing (DON) stated Resident 1 ' s clinical records did not contain blood tests results ordered on 12/26/24. The DON stated the tests should have been performed on 12/26/24 because it was ordered STAT. The DON validated that the ' Patient Service Log ' dated 12/27/24 did not show if Resident 1 ' s blood tests were done. The DON stated that she was not sure if the tests were carried out and if the nursing staff followed up with laboratory staff addressing Resident 1 ' s laboratory tests. The DON stated the facility called the laboratory clinic and were waiting for the clinic ' s call back. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the undated document provided by the facility and titled, LABORATORY PROCEDURES, indicated, STAT requests must be made through the 24 hour call center .A call to the 24 hour call center will prevent delays. These requests are reserved for CRITICAL LIFE THREATENING REQUESTS ONLY .When the phlebotomist [a medical professional who draws blood for testing] is unable to draw or there is a refusal or other condition which prevents the completion of the lab test(s) requested, the phlebotomist will obtain the charge nurse initials on the requisition slip to verify the facility has been notified of these circumstances . STATS are given top priorities. During a follow up telephone interview on 1/10/25, at 10:30 a.m., the DON confirmed that the blood tests that were ordered to be completed STAT on 12/26/24 for Resident 1 were not carried out. The DON explained that per the facility ' s policy, all STAT blood tests were required to be performed in 4 -6 hours. The DON stated that per laboratory clinic, Resident 1 refused the blood draw on 12/26/24. The DON stated the nurse notified the physician but did not document the notification and did not document that the blood tests were rescheduled for 12/31/24. The DON stated her expectation was that the nurse documented the physician notification in the progress notes. The DON acknowledged that Resident 1 ' s clinical records had no documented evidence to support facility ' s notification of physician of Resident 1's refusal of the laboratory tests and there was no documented evidence that the tests were rescheduled for 12/31/24. The DON was asked if not carrying physician ' s order and not completing blood tests contributed to Resident 1 ' s continuing having bladder infection and hospitalization and the DON did not provide any answer.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 38834 Based on interview and record review, the facility failed to maintain complete and accurate medical records for one of four sampled residents (Resident 1), when there was documentation that the blood tests ordered by physician were performed and there was no documentation the physician was notified of resident's refusal of the lab tests. In addition, the order to reschedule blood tests for later date was not entered into Resident 1 ' s records. These failures resulted in the confusion among the facility ' s staff whether the tests were performed as ordered and had the potential to result in Resident 1's continued deterioration of health. Findings: A review of Resident 1 ' s admission record indicated the facility admitted the resident in 2023 with multiple diagnoses which included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control), lung and heart diseases. A review of Resident 1 ' s clinical records contained documentation dated 12/16/24 which indicated that the resident had been diagnosed with urinary tract infection (UTI, a bladder infection). A review of Resident 1 ' s physician order dated 12/26/24, at 1.08 p.m., contained a physician order for two blood tests. One of the ordered tests was to check if the resident responded to treatment for UTI or if she still had the bladder infection. According to physician order, both blood tests were ordered to be completed STAT (a medical term that means immediately, without delay). A review of facility document titled, Patient Service Log dated 12/27/24 contained name of three residents, including Resident 1 ' s name. The left side of the document contained residents ' names and the blood tests that were to be done for the residents. The right side of the document indicated the dates the tests were performed. Resident 1 ' s blood tests had no documentation if they were completed, cancelled, or rescheduled. A review of Resident 1 ' s clinical record indicated there was no documented evidence the ordered blood tests were performed on 12/26/24 and the resident ' s medical records did not contain results of the blood tests ordered on 12/26/24. During an interview on 1/8/25, at 4:25 p.m., Licensed Nurse (LN 2) explained that the STAT order means right away, immediately and added that the staff had to follow up with the laboratory to inform them of STAT blood tests. LN 2 stated that the physician had to be notified right away if the resident refused the blood tests and the test was not completed. LN 2 stated resident ' s refusal and communication with the physician should be documented in the progress notes. A review of the facility ' s ' Telephone Orders ' policy dated 2/2017, indicated, Verbal telephone orders .must be .recorded in the resident ' s medical records .The entry must contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/9/25, at 4:43 p.m., the Director of Nursing (DON) stated Resident 1 ' s clinical records did not contain blood tests results ordered on 12/26/24. The DON stated the tests should have been done on 12/26/24 because it was ordered STAT. The DON validated that the ' Patient Service Log ' dated 12/27/24 did not show if Resident 1 ' s blood tests were done. The DON went on to say that she was not sure if the tests were carried out and if nursing staff followed up with laboratory staff addressing Resident 1 ' s laboratory tests. The DON stated the facility called the laboratory clinic and were waiting for the clinic ' s call back. During a follow up telephone interview on 1/10/25, at 10:30 a.m., the DON confirmed that the blood tests that were ordered to be completed STAT on 12/26/24 for Resident 1 were no carried out. The DON stated that the laboratory clinic reported that Resident 1 refused the blood draw. The DON stated the nurse notified the physician but did not document the notification and did not document that the blood tests were rescheduled for 12/31/24. The DON stated her expectation was that the nurse documented the physician notification in the progress notes. The DON acknowledged that Resident 1 ' s clinical records had no documented evidence to support facility ' s notification of physician of the laboratory tests refusal and there was no documented evidence that the tests were rescheduled for 12/31/24. A review of the facility ' s policy titled, Charting and Documentation, dated 2/2017, indicated, All services provided to the resident .or any changes in the resident ' s medical, physical, functional or psychosocial conditions, shall be documented in the resident ' s medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident ' s condition and response to care . Documentation in the medical record will be .complete and accurate .Documentation .will include .the date and time the procedure/treatment was provided .whether the resident refused the procedure/treatment . notification of .physician or other staff.		