

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555861	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER Grand Oaks Care		STREET ADDRESS, CITY, STATE, ZIP CODE 897 North M Street Tulare, CA 93274	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>38993</p> <p>Based on interview and record review, the facility failed to ensure the Physician and Responsible Party (RP) was notified of an injury for one of three sampled residents (Resident 1). This failure resulted in the Physician and RP being unaware of the injury.</p> <p>Findings:</p> <p>During a review of the S (Situation) B (Background) A (Appearance) R (Review and Notify) (SBAR) dated 4/20/24 at 9:50 p.m., the SBAR indicated, The change in condition, symptoms, or signs observed and evaluated is/are: Falls.</p> <p>During a review of Resident 1's Progress Notes (PN) dated 4/21/24 at 6:32 a.m., the PN indicated, Resident returned from ER (emergency room) at approx.(approximately) 0620 (6:20 a.m.).Resident has abrasion to bilateral shins with discoloration.</p> <p>During a concurrent interview and record review on 5/8/24 at 3:10 p.m. with Director of Nursing (DON), DON reviewed Resident 1's PN's and was unable to provide evidence of the Physician and RP being notified of the abrasions to bilateral shins. DON stated the RP reported the abrasions to her when Resident 1 was still at the hospital after the fall. DON stated the Physician and the RP should have been notified of the abrasions.</p> <p>During a review of the facility's policy and procedure (P&P) titled Notification of Changes dated 5/1/22, the P&P indicated, The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: 1. Accidents a. resulting in injury.</p>

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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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>38993</p> <p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of three residents (Resident 1) call light was in working order. This failure had the potential for staff to be unaware of Resident 1 needing assistance.</p> <p>Findings:</p> <p>During an observation on 4/24/24 at 1:43 p.m. in Resident 1's room, Resident 1's call light button was pressed. When the call light button was pressed the call light did not turn on outside of the room or in the hallway.</p> <p>During a concurrent observation and interview on 4/24/24 at 1:55 p.m. with Certified Nursing Assistant (CNA) 1 in Resident 1's room, CNA 1 pressed the call button, and the call light did not light up outside of the room or in the hallway. CNA 1 stated Resident 1 used the call light to ask for assistance and she was going to notify maintenance that the call light was not working.</p> <p>During a concurrent observation and interview on 4/24/24 at 2:03 p.m. with Maintenance Director (MD), in Resident 1's room, MD inspected the call light and stated the call button was pushed all the way in and the call light was not working.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light dated 9/22, the P&P indicated, Be sure the call light is plugged in and functioning at all times.</p> <p>During a review of the facility's (P&P) titled, Call System, Residents dated 9/22, the P&P indicated, The resident call system remains functional at all times.If visual communication is used, the lights remain functional.The resident call system is routinely maintained and tested by the maintenance department.</p>		