

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 07/03/2025
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>Based on interview and record review, the facility failed to ensure the responsible party (R/P) was notified when there was a change of condition for one of three sampled residents (Resident 1). This failure resulted in the R/P being unaware of Resident 1's change of condition. Findings: During a review of Resident 1's S (situation) B (background) A (appearance) R (Review and Notify) Communication Form (SBAR-used to notify the physician of a change of condition), dated 6/14/25 at 11:24 p.m., the SBAR indicated, At 8:11 p.m. res (resident) was note (sic) with gurgling sounds to throat, upon assessment, it was noted that patient had burning sensation when urinating per patient, increased confusion per staff, and res stated throat hurts. MD (Doctor of Medicine) (physician name) made aware at 8:15 p.m. and made order to suction res prn (as needed) and for an ST (speech therapy) eval (evaluation). Advised staff and patient to increase fluids. There was no documentation the R/P was notified. During a concurrent interview and record review on 7/3/25 at 1:16 p.m. with Assistant Director of Nursing (ADON), ADON reviewed Resident 1's SBAR dated 6/14/25 and stated the R/P was not notified of the change of condition and she should have been. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status dated 2/2021, the P&P indicated, Unless otherwise instructed by the resident, a nurse will notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status.</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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