STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055204	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKWOOD GARDENS CARE CENTER	3510 EAST SHIELDS FRESNO, CA 93726

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** Based on observation, interview and record review, the facility failed to ensure resident call lights were easily accessible and within reach for one of 38 sampled residents (Resident 62). This deficient pra resulted in Resident 62's embarrassment when he did not have a call light to call for help which caused him to urinate on himself and prevented Resident 62's needs from being met. Findings: During a concurrent observation and interview, on 3/2/20, at 12:05 p.m., through 12:13 p.m., in Resident 62's room. Resident 62's call light was wrapped around the bed frame and out of Resident 62's reach. Resident 62 was lying on the bed in his room and stated, Move my leg. Take me to the hospital. Need the bathroom. Resident 62's words were garbled and difficult to understand. Resident 62 had a full-leg splint (a devise made of a rigid material used for supporting and immobilizing a bone) on his left leg. Resident 62 turned onto his left side and urinated on the mattress. Resident 62 continued to call out for help. Resident 62 was unable to activate the call light (pushed the button to activate a light and audible ring). The call light remained wrapped around the bed frame and out of Resident 62's reach. Resident 62 did not answer questions when asked about his call light. During a concurrent observation and interview on 3/2/20, at 12:13 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 and CNA 2 walked into Resident 62's room and stated the call light was wrapped around the bed frame and was not within Resident 62's reach and it should have been. During an interview on 3/2/20, at 12:23 p.m., with CNA 2, CNA 2 stated Resident 62 was unable to use his call light because it had been attached to the bed frame and not within his reach. CNA 2 stated Resident 62's call light should have been placed in an area of the bed where he would have easy access and that did not occur. CNA 2 stated Resident 62's inability to access his call light and call for help resulted in Resident 62 having to urinate on his bed. During a concurrent interview and record review on 3/5/20, at 11:16 a.m., with the Director of Nursing (DON), the DON reviewed the Interdisciplinary Team (IDT - team made up of the Administrator, the DON, the Social Services Director, the Activities Coordinator) progress note, dated 3/2/20, at 5:09 p.m., which indicated, .IDT went to the patient's room to assess the call light. It was clipped to his sweater. He was able to press it (call light) several times . The DON stated the call light had a clip on it and should have been placed within Resident 62's reach on 3/2/20. The DON reviewed the fall care plan dated on 3/2/20 which included the intervention, .During rounds monitor placement of call light . call light to be clipped to (Resident 62's) clothing or blanket. During a review of the facility policy titled, Accommodation of Needs dated 1/2011, indicated, Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being . In order to accommodate individual needs . adaptations may be made to the physical environment, including the resident's bedroom . Examples of such adaptations may include . a. Providing access to assistance devices (call light) . During a review of the facility policy titled, Answering the Call Light dated 2001, indicated, .The purpose of this procedure is to respond to the resident's requests and needs. General Guidelines . 4. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** Based on observation, interview, and record review, the facility failed to develop a baseline care plan for one of 16 sampled residents (Resident 186) when Resident 186 was taking anticoagulation (AC - medications that slow down clot formation and have the potential to increase bleeding) medication and a baseline care plan was not developed for the use of the anticoagulation medication. This deficient practice placed Resident 186 at risk for episodes of bleeding not being detected and monitored timely. Findings: During a concurrent interview and record review on 3/4/20, at 11:04 a.m., with the Director of Nursing (DON), the DON reviewed Resident 186's admission physician order dated 2/23/20, which indicated rivaroxaban to (an anticoagulant medication) 20 milligram (mg - a metric measurement) tablet, one tablet by mouth daily. The DON stated Resident 186 was administered rivaroxaban since admission to the facility. The DON reviewed Resident 186's care plans and stated Resident 186 did not have a care plan to monitor rivaroxaban's high risk side effects such as bleeding and there should have been a care plan developed. The DON provided and reviewed the newly developed care plan titled, ANTICOAGULANT CARE PLAN dated 3/4/20, which indicated, (Resident 186) Is at risk for bleeding/bruising secondary to: Anticoagulant Therapy (rivaroxaban) . intervention . Observe for blood in urine, bruises, changes in LOC (level of consciousness), blood in stool, epistaxis (nose bleeds). During a concurrent interview and record review on 3/4/20, at 2:44 p.m., with the Director of Staff Development (DSD), the DSD reviewed Resident 186's clinical record and stated Resident 186's rivaroxaban was a drug with high-risk for side effects and should have been care planned within 48 hours of receiving the order and it was not. The DSD stated the Anticoagulant Use - (rivaroxaban) 20 mg was identified on the Observation Detail List Report (an alert for the license nurses) dated 2/24/20, which indicated .Admission -- (2) Baseline Care Plan: Person-Centered Care Planning . What Nursing Services Will be Provided to Meet Resident Individualized Goals for Care? The DSD stated the medication rivaroxaban was clearly identified on the Observation Detail report on admission as requiring baseline care plan and it should have had a baseline care plan developed within 48 hours but that did not occur. During a review of the facility policy and procedure titled, Care Plans - Baseline dated 12/16, indicated, A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission . 1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. 2. The Interdisciplinary Team will review the healthcare practitioner's orders 9 . medications . and implement a baseline care plan to meet the resident's immediate care needs including but not limited to . a. Initial goals based on admission orders [REDACTED].
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide [MEDICAL TREATMENT] (the process of artificial filtering and removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions) services consistent with professional standards of practice for one of two sampled [MEDICAL TREATMENT] residents (Resident 188) when the SNF (Skilled Nursing Facility)/[MEDICAL TREATMENT] Assessment Communication Form (SNF/DACF - form used to communicate pertinent [MEDICAL TREATMENT] resident assessment information between the facility nursing staff and [MEDICAL TREATMENT] center staff to ensure residents are in stable condition prior to and after [MEDICAL TREATMENT] treatment) was incomplete on three of three sampled forms. This deficient practice resulted in inaccurate pre (before) and post (after) [MEDICAL TREATMENT] assessment and communication of Resident 188's status and placed resident at increased risk of experiencing undetected adverse reactions from [MEDICAL TREATMENT] treatment.

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

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F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Findings: During a concurrent observation and interview on 3/2/20, at 10:53 a.m., Resident 188 stated she was new to the facility and had peritoneal [MEDICAL TREATMENT] (PD- a type of [MEDICAL TREATMENT] in which the lining of the abdominal cavity is used as a filtration membrane for removal of waste products) for the past three years before coming to the facility. Resident 188 stated she still had the PD line (tubing or catheter to form a connection to allow filtration of blood) on her right groin and planned to return to PD after discharge from the facility. Resident 188 stated she was required to switch from PD to [MEDICAL TREATMENT] (HD - the most common form of [MEDICAL TREATMENT], where blood is drawn from your body into a machine that filters out all the toxins in your blood, then pumps the blood back into your body) during her stay at the facility. Resident 188 stated switching from PD to HD required the insertion of a new [MEDICAL TREATMENT] line. Resident 188 displayed the new HD line site on her upper right chest. The HD line had two tails (a soft plastic tube (twice the length and half the width of a pen) placed through the skin into one of the large veins in the neck) one red, and one blue. The HD site was covered with a clean, dry white bandage. Resident 188 stated she received [MEDICAL TREATMENT] treatments three days a week on Monday, Wednesday and Fridays. During a review of the clinical record for Resident 188, the Face Sheet (a document containing resident demographic information) undated, indicated Resident 188 was admitted on [DATE] with [DIAGNOSES REDACTED]. The clinical record contained three SNF/DACFs with both pre and post [MEDICAL TREATMENT] assessment findings dated 2/21/20, 2/24/20, and 2/26/20 on each form. The three SNF/DACFs inaccurately indicated assessment findings for Thrill (a pulsing sensation) and Bruit (the swishing sound heard with a stethoscope) present during assessment as YES which Resident 188's HD access site would not have. During a concurrent interview and record review on 3/3/20, at 2:26 p.m., with the Director of Nursing (DON), the DON reviewed the SNF/DACF [MEDICAL TREATMENT] assessment forms and stated the purpose of the SNF/DACF was to establish and accurately communicate details of Resident 188's baseline assessment to quickly identify any change of condition in Resident 188's [MEDICAL TREATMENT] site or health status. The DON stated the SNF/DACF was the main interfacility communication form between the SNF and the [MEDICAL TREATMENT] center. The DON stated the three SNF/DACFs assessment forms, both before and after [MEDICAL TREATMENT], inaccurately documented a bruit and a thrill which Resident 188's HD site assessment would not have. The DON stated the license nurses were expected to accurately document the assessment findings on the SNF/DACF and they were not. During a concurrent interview and record review on 3/3/20, at 2:30 p.m., Licensed Vocational Nurse (LVN) 1 stated, I completed the pre-[MEDICAL TREATMENT] SNF/DACF dated 2/26/20, and it is inaccurate. I documented YES to the presence of the Bruit and Thrill . LVN 1 stated Resident 188's HD site would not have a bruit or a thrill. LVN 1 indicated the only way to detect bruit and thrill was to touch the [MEDICAL TREATMENT] site and listen using a stethoscope. During a concurrent interview and record review on 3/3/20, at 2:52 p.m., with Registered Nurse (RN) 1, RN 1 stated she had marked that she assessed for bruit and thrill on the three SNF/DACFs in error. RN 1 stated Resident 188's HD would not have a bruit or thrill. RN 1 stated Resident 188's assessments were incorrect. During a review of the facility policy and procedure titled, [MEDICAL TREATMENT] Services, dated 11/17, indicated, It is the policy of the facility that each resident receives care and services for the provision of [MEDICAL TREATMENT] consistent with professional standards of practice including the: Ongoing assessment of the resident's condition and monitoring for complications before and after [MEDICAL TREATMENT] treatments received at a certified [MEDICAL TREATMENT] facility . Ongoing communication and collaboration with the [MEDICAL TREATMENT] facility regarding [MEDICAL TREATMENT] care and services . During a review of the facility policy and procedure titled, [MEDICAL CONDITION], Care of a Resident with dated 9/10, indicated, Residents with [MEDICAL CONDITIONS] will be cared for according to currently recognized standards of care .1. Staff caring for residents with [MEDICAL CONDITION], including residents receiving [MEDICAL TREATMENT] care outside the facility, shall be trained in the care and special needs of these residents. 2. Education and training of staff includes, specifically: .b. The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis . During a review of the facility policy and procedure titled, Charting and Documentation dated 7/17, indicated, .All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record . Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate .
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure food items and dishware were stored in a sanitary manner when: 1. One container of coffee creamer was torn and leaking onto other food items in the walk-in refrigerator. 2. Two steam table food pans were not air dried and stored away wet. These deficient practices placed residents at risk of consuming contaminated food and having food prepared in unsanitary food pans could lead to foodborne illness. Findings: 1. During a concurrent observation and interview on [DATE], at 8:13 a.m., in the walk-in refrigerator, a container of coffee creamer was on a tray with liquid leaking from the bottom of the coffee creamer carton. The Dietary Manager (DM) stated the coffee creamer needed to be discarded from the refrigerator because it was torn and leaking, and air could enter inside the carton and cause it to spoil. The DM stated if the coffee creamer were to become spoiled, staff would not be aware and could possibly serve spoiled coffee creamer to residents. The DM stated spoiled food items should not be given to the residents because it could cause residents to become sick. During an interview with the Registered Dietician (RD), on [DATE], at 3:45 p.m., the RD stated the coffee creamer was compromised when it was found leaking. The RD stated if the creamer would have been left in the walk-in refrigerator for days it could have spoiled and if given to the residents it could have made the residents ill. During a review of the facility policy and procedure titled, Food Storage-Dented Cans dated 2018, indicated, Food in .leaking .containers .shall not be retained or used by the facility .All leaking cans are to be disposed of immediately. 2. During a concurrent observation and interview on [DATE], at 9 a.m., in the kitchen near the dishware storage area, there were two steam table pans with flesh water drops on them. The DM stated the steam table pans needed to be air dried before being stored. The DM stated it was important to have the steam table pans air dried because water could attract bacteria that could potentially grow on the pans. The DM stated if residents were to eat food that was on bacteria contaminated pans, residents could get sick. During an interview with the RD, on [DATE], at 3:45 p.m., the RD stated the steam table food pans needed to be air dried before being stored. The RD stated dietary staff needed to make sure there was no condensation (water drops) on the pans to prevent any cross contamination (process by which bacteria are unintentionally transferred from one substance or object to another with harmful effect) and lead to illness for the residents. During a review of the facility policy and procedure titled, Dish Washing dated 2018, indicated, .5. Dishes are to be air died in racks before stacking and storing .
F 0813 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a policy regarding use and storage of foods brought to residents by family and other visitors.** Based on observation, interview and record review, the facility failed to provide for the storage of foods brought to residents from outside sources, when the facility policy did not allow residents to store food brought in by family or visitors. This failed practice prevented residents from exercising their rights to store food in the facility that was brought in from outside sources. Findings: During a concurrent observation and interview on 3/3/20, at 10:13 a.m., near the nursing unit, food items from the kitchen were stored in the unit refrigerator. The Dietary Manager (DM) stated food items stored in the unit refrigerator were from the kitchen. The DM stated food items were for nurses or activities personnel to distribute to residents if residents wanted a snack in the evening or throughout the day. The DM stated the facility did not allow food brought in by visitors from outside the facility to be stored in the unit refrigerator. The DM stated the facility policy did not allow storage of food brought in from outside sources. The DM stated residents had to eat food brought in by visitors at the time of the visit. The DM stated residents' food brought in by visitors needed to be discarded after two hours. During an interview with the Registered Dietician (RD), on 3/4/20, at 3:30 p.m., the RD stated residents were not allowed to store food brought in by visitors in the unit refrigerator. The RD stated residents needed to eat perishable food (type of food that will go bad quickly if left out of the refrigerator) at the time food was brought to the resident and then discarded after two hours. The RD stated the facility policy did not allow storage of perishable food

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F 0813 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) brought in by visitors. During an interview with the Administrator (ADM), on 3/4/20, at 3:54 p.m., the ADM stated the facility did not have a policy to allow food brought in by visitors for residents. The ADM stated the facility did not have a policy and procedure that would allow the storage of food brought in from outside sources into the facility. The ADM stated residents' perishable food from outside sources needed to be discarded if not eaten within two hours. During a review of the facility policy and procedure titled, Foods Brought in by Family/Visitors from Outside Sources undated, indicated, .5. Perishable foods must be consumed at time of visit and cannot by stored for the resident by the facility. 6. The nursing staff is responsible for discarding perishable foods kept at bedside for greater than 2 hours .
F 0911 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure resident rooms accommodated no more than four residents each, when rooms [ROOM NUMBERS] housed a total eight residents, room [ROOM NUMBER] and 29 housed a total eight residents, room [ROOM NUMBER] and 36 housed a total eight residents, and room [ROOM NUMBER] and 39 housed a total eight residents. This failed practice had the potential for residents to not have a reasonable amount of privacy or adequate space. Findings: Throughout the survey period from 3/2/20 through 3/5/20, observations and interviews were conducted for the following rooms: room [ROOM NUMBER], 11, 27, 29, 34, 36, 38, and 39. There was an open partition between room [ROOM NUMBER] and room [ROOM NUMBER] which would allow visitors, staff and residents to enter both rooms freely without accessing a door. There were four residents occupying room [ROOM NUMBER] and four residents occupying room [ROOM NUMBER], totaling eight residents with the shared open partition in the center wall of both rooms. The same configuration was observed for room [ROOM NUMBER] and 29, room [ROOM NUMBER] and 36, and room [ROOM NUMBER] and 39. During survey observations and residents and staff interviews reasonable amount of privacy was provided and adequate closet, storage space was available. There was sufficient space for residents and staff to provide resident care. Wheelchairs and toilet facilities were accessible to residents. Nursing care of the residents was not impacted. Recommend room waiver. _____ Health Facilities Evaluator Supervisor II Signature and Date _____ Administrator Signature and Date _____
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call lights were functioning properly for one of 36 sampled rooms (Rm 39) and four of four sample residents (Resident 11, 13, 50, and 76) when the call light monitor in Rm 39 was not blinking nor sounding at the nurse's station, and the Maintenance Director (MD) did not document call light equipment checks. This failed practice had the potential to result in resident call lights not being answered timely and for emergent situations to be undetected by staff which could lead to resident injuries and/or harm. Findings: During a concurrent observation and interview on 3/2/20, at 11:02 a.m., in room [ROOM NUMBER], Resident 50 stated his call light was not working. Resident 50 stated he needed assistance on 2/28/19 to put on his socks and noticed the call light was not functioning. Resident 50 pushed his call light, and call light monitor above room [ROOM NUMBER] did not light. Resident 50 did not recall who he informed about the call light functioning as he did not use the call light frequently for assistance. Resident 50 stated he had changed rooms but could not recall when or how long the call light was not functioning. During a review of the clinical record for Resident 50, the Minimum Data Set (MDS - resident assessment for cognitive function) assessment dated [DATE], indicated Resident 50 had no cognitive impairment. During a concurrent observation and interview on 3/2/20, at 11:35 a.m., in room [ROOM NUMBER] with Certified Nursing Assistant (CNA) 3, CNA 3 entered room [ROOM NUMBER] and pushed the call light button to activate the call light for Resident 11, 13, and 76. The call light monitor did not light. CNA 3 left the room to check if the call light was functional at the nurses' station and stated room [ROOM NUMBER]'s call button was not flashing at the nurse's station. CNA 3 stated when call lights were non-functional in resident rooms, bells were given to residents as a temporary call system. CNA 3 stated when staff knew about call lights not functioning, they needed to place an repair order for maintenance department to repair the call light. CNA 3 gave resident 11, 13, 50, and 76 bells at bedside and called the maintenance department to repair call lights. During an interview with the MD, on 3/2/20, at 11:51 a.m., the MD stated call light checks were performed two times a week, on Mondays and Fridays to ensure call lights were functioning. The MD stated he did not document room call light checked on those days. The MD stated he documented repairs of the call light system when nursing staff informed him of call lights not functioning. The DM stated he did not know how long the call lights were not working for room [ROOM NUMBER] and was unable to find documentation indicating he was performing maintenance checks for functional call lights. During an interview with Resident 11, on 3/2/20, at 3 p.m., Resident 11 stated he would yell out for help when he needed someone. Resident 11 stated did not know how long the call light was not functioning. During an interview with Resident 13, on 3/2/20, at 3:10 p.m., Resident 13 stated he could use the call light and would use it if he needed assistance. Resident 13 stated he did not recall the last time he used the call light. Resident 13 stated he did know the call light was not functioning. During a review of the clinical record for Resident 13, the MDS assessment dated [DATE], indicated Resident 13 was moderately cognitively impaired. During a concurrent interview and record review on 3/3/20, at 10:49 a.m., with the MD, the MD reviewed the facility Logbook Documentation dated 2/25/20, which indicated station 3 rooms (Rm 39) had bulbs replaced and call light system was functioning on 2/7/20. The MD stated station 3's call lights were functioning on 2/7/20, but he did not know when room [ROOM NUMBER]'s call light quit functioning because the call light system tests performed twice a week were not documented. During an interview with the Administrator (ADM), on 3/4/20, at 4 p.m., the ADM stated the MD was documenting only when call light repairs were done and did not document call light testing checks completed twice a week. The ADM stated the last documented call light repair on room [ROOM NUMBER] was 2/7/20. The ADM stated the MD should have been documenting all call light testing checks. The ADM stated the facility did not have a policy on how often call light testing was performed or when to document the call light testing. During a review of the facility policy and procedure titled, Answering the Call Light dated 2001, indicated, .The purpose of this procedure is to respond to the resident's requests and needs . check . Report all defective call lights to the nurse supervisor promptly .ensure call light in working order .