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 _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS HEALTHCARE CENTER	11300 FAIR OAKS BLVD. FAIR OAKS, CA 95628

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of complaint #CA00901270 and #CA00901274. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 48140 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. The Department substantiated complaint #CA00901270, and a violation of regulations was written under tag F-580, F-642, F-657, and F-689. The Department substantiated complaint #CA00901274, and a violation of regulations was written under tag F-658.	F 000	POC Received 7/3/2024 POC Approved 7/9/2024 BIC = 7/9/2024 per ADJ	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		

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

Administrator 7-3-24

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.

"This plan of correction is prepared in response to the deficiencies identified in the CMS Forn 2567. It is intended to address the concerns raised by the survey findings and to outline the corrective actions taken or planned to ensure compliance with regulatory requirements. This document serves as a formal acknowledgement of the deficiencies cited and our commitment to rectify them promptly and effectively. However, it does not constitute an admission of fault or liability on the part of Fair Oak Healthcare Center. It is provided for informational purposes only and should not be construed as a waiver of any rights or remedies available to Fair Oaks Healthcare Center under applicable laws and regulations."

F580 Notify of Changes:

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
A licensed nurse had notified the RN Nurse Practitioner on 4/22/2024 at 10:10 hours and ordered to monitor the site. The licensed Nurse assumed that since the resident called and spoke with her son while the Licensed Nurse was witnessing the phone conversation, there was no need for him (Licensed Nurse) to speak with the son (RP).
The DON provided immediate re-education to the Licensed Nurse the importance of notifying the RP/ or family member with the change of condition. Date completed 04/26/2024

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.
All residents have the potential to be affected by the same deficient practice. The clinical team are reviewing and updating the list for the responsible party for immediate notification, if needed.

Date of completion: 07/09/2024

What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.
The Director of Nursing conducted re-education Inservice to the Licensed Nurses on the Policy and Procedure " Change in a Resident's Condition or Status".

Date of completion: 06/28/2024

How the facility plans to monitor its performance to make sure that solutions are sustained.
Medical record staff will conduct a regular audit for change of condition 5x a week for 4 weeks to assess compliance and identify areas of improvement , then randomly as determined by QA committee. Findings will be brought to QA committee monthly and quarterly.

The director of Nurses and /or her Designee will be responsible for monitoring compliance.

Date of completion:07/09/2024

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F 657 Care Plan Timing and Revision

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
Resident 1's blisters on left fingers healed/resolved on 05/19/2024
A Comprehensive care plan has been updated / revised to reflect resident 1 current condition.
Date completed 05/19/24

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.
The Inter-Disciplinary Team (IDT) is reviewing the 9 identified residents who have Diagnosis of Parkinson's Disease for comprehensive care plan. Care plans are updated and revised accordingly based on the resident's goals and needs.

Date of completion: 07/08/2024

What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.
The Director of Nursing conducted a re-education Inservice on the policy and procedures on Comprehensive Care Planning.

Date of completion: 06/28/2024

How the facility plans to monitor its performance to make sure that solutions are sustained.
Medical record staff will perform a regular audit on residence care plan to ensure that the care plan is revised in a timely manner, 5x a week for 4 weeks, then randomly weekly.
Findings will be brought to QA committee monthly and quarterly.

The director of Nurses and /or her Designee will be responsible for monitoring compliance.

Date of completion:07/09/2024 and ongoing.

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F642

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

On 4/22/24 Licensed Nurse notified the RN Nurse Practitioner who is on duty (office located in the facility) regarding the 2 blisters to the left fingers. The RN Nurse Practitioner ordered to observe the affected areas.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

Census on 6/25/2024 was 122. There are 9 Like residents identified as having the diagnoses of Parkinson's Disease.

The facility requests correction on the statement" On 4/26/24, at 12:15 pm, the Assistant Director of Nursing (ADON), who is also LVN". The facility Assistant Director of Nursing is a Registered Nurse (RN).

The facility has a Registered Nurse (RN) on duty every shift.

The Clinical team is reviewing the residents' assessments to ensure that they are accurately signed.

What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.

In service education was conducted by the Director of Nursing on the "Coordination and certification of assessment" With the emphasis of having the Registered Nurse conclude the assessment.

A review of California RN Practice Act and LVN Practice Act was discussed.

Date of Inservice: 06/28/2024

How the facility plans to monitor its performance to make sure that solutions are sustained.

Medical Record staff will conduct audits for the comprehensive assessment 5x a week for 4 weeks. Findings will be brought to QA monthly and quarterly.

Date of Completion: 07/10/2024 and ongoing.

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F 658

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

Resident 1 has been discharged for the facility on 4/26/2024

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

Census on 6/25/24 was 122, There are 22 residents identified to have orders for wound care.
The clinical team are assessing the residents wound care needs.
Individual care plan for wound care needs is reviewed and developed based on the assessment findings, ensuring that the resident's specific needs, risk factors, and preferences are addressed.

Date of completion: 07/08/2024

What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.

Director of Nursing provided re-education Inservice and training on "following Physician's order"

Date of completion: 06/28/2024

How the facility plans to monitor its performance to make sure that solutions are sustained.

Medical record staff will conduct regular audits of treatment administration record (TAR) for completion and documentation of wound care 5x a week for 4 weeks to assess for compliance and identify areas of improvement, then randomly as determined by the QA committee.
Findings will be brought to QA committee monthly and quarterly for tending and to make continuous improvement and ensure the highest standards of care are maintained.

The director of Nurses and /or her Designee will be responsible for monitoring compliance.

Date of completion:07/09/2024 and ongoing.

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F 689 Free of Accident Hazards/Supervision/Devices

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

The Director of Staff Development (DSD) provided immediately re-education to the Certified Nursing Assistant (CNA) on process of reheating food and providing assistance with feeding on 04/23/24
Resident 1 was assessed by LN and Nurse Practitioner/ MD was notified.

Resident 1's blisters on left fingers healed/resolved on 05/19/2024
A Comprehensive care plan has been updated / revised to reflect resident 1 current condition.
Date completed 05/19/24

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

Census on 6/25/24 was 122, There are 9 Liked residents with Dx of Parkinson's Disease were identified.
Residents are reviewed and updated accordingly.

Date of completion: 07/08/2024

What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.

Director of Nursing and Director of Staff Development conducted an Inservice to nursing staff of the Policy and Procedure on " Reheating food" on 06/28/2024.
Microwaves were removed from each nurses' station on 06/28/24.
9 Identified residents were referred to Rehab for screening. The Occupational therapy Department is screening and evaluating the needs of adaptive devices and level of assistance/ support required. Care plans and tasks will be updated according to the finding on evaluation.

Date of completion: 07/09/24

How the facility plans to monitor its performance to make sure that solutions are sustained.

Medical record staff will conduct regular audits of CNA tasks documentation are being followed 5x a week for 4 weeks to assess for compliance and identify areas of improvement, then randomly as determined by the QA committee.
The Director of Staff Development will conduct 5x a week for 4 weeks on staff observation for feeding assistance, and randomly each week.
Findings will be brought to the QA committee monthly and quarterly for tending and to make continuous improvement and ensure the highest standards of care are maintained.

The director of Nurses and /or her Designee will be responsible for monitoring compliance.

Date of completion:07/09 2024 and ongoing.

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F 580	Continued From page 1 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to promptly notify Resident 1's Responsible Party (RP) or Family Member (FM) when Resident 1 experienced burns to two fingers.	F 580		

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F 580	Continued From page 2 This failure resulted in Resident 1 feeling as if the facility did not take her injury seriously. Findings: A review of Resident 1's admission record indicated Resident 1 was admitted to the facility in May 2020 with diagnoses including parkinsonism (brain conditions that cause tremors) and ataxia (loss of muscle control in arms and/or legs). A review of a nurse progress note dated 4/22/24 at 2:33 p.m. indicated, "[Resident 1] was attempting to feed self this AM [morning] without CNA assistance. Due to tremors [Resident 1] spilled hot cereal over and burn 2 fingers to left hand. Index finger blister measuring apprx [approximately] 2.5x1 ...middle finger 2x2. [Resident 1] was advised to wait for staff to assist w [with] feeding. NP [Nurse Practitioner] ...wrote new orders to monitor site. " There was no documented evidence Resident 1's RP or FM was notified of Resident 1's injury when it occured. During a review of Resident 1's change of condition evaluation (eCOC) dated 4/26/24 at 11:42 a.m., completed by LN 1, the eCOC indicated Resident 1 had a, "boil to index (left hand) finger 2.5 x 1, middle finger 2 x 2, burn with hot cereal. Family Member 1 (FM 1)`notified on 4/26/24 at 11:25 a.m. " During a review of Resident 1's progress Note dated 4/26/24 at 12:15 p.m. indicated Resident 1's FM 1 was concerned Resident 1's fingers were burned and the facility had not notified FM 1 of the incident.	F 580		

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F 580	Continued From page 3 During an interview on 6/5/24 at 1:45 p.m. with the Director of Nursing (DON), the DON stated the resident's RP or FM was expected to be notified when an accident or change of condition occurs for the resident. During a telephone interview on 6/11/24 at 12:40 p.m. with the LN 1, the LN 1 confirmed he did not notify Resident 1's FM about the accident with injury. During a review of the facility's policy and procedure (P&P) titled, "Change in a Resident's Condition or Status, " revised February 2021, indicated, "Our facility promptly notifies ...the resident representative of changes in the resident's medical/mental condition and/or status ...A nurse will notify the resident's representative when: the resident is involved in any accident or incident that results in an injury ... "	F 580		
F 642 SS=D	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification.	F 642		

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F 642	Continued From page 4 §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to ensure the accuracy of assessments for one resident (Resident 1) when Resident 1 did not receive timely and adequate assessments of her injuries. This failure resulted in Resident 1's inaccurate and inconsistent assessments of her injuries, a lack of diagnosis for her injuries, and a delay in appropriate treatment. Findings: A review of Resident 1's admission record indicated Resident 1 was admitted to the facility in May 2020 with diagnoses including parkinsonism (brain conditions that cause tremors) and ataxia (loss of muscle control in arms and/or legs). A review of a nurse progress note dated 4/22/24 at 2:33 p.m. written by Licensed Vocational Nurse 1 (LVN 1) indicated, "[Resident 1] was attempting to feed self this AM [morning] without CNA [Certified Nursing Assistant] assistance. Due to	F 642		

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F 642	Continued From page 5 tremors [Resident 1] spilled hot cereal over and burn 2 fingers to left hand. Index finger blister measuring apprx [approximately] 2.5x1 ...middle finger 2x2. [Resident 1] was advised to wait for staff to assist w [with] feeding. NP [Nurse Practitioner] ...wrote new orders to monitor site. " A review of Resident 1's nurse progress notes indicated the following: On 4/26/24 at 12:15 p.m., the Assistant Director of Nursing (ADON) who is also an LVN, documented, "Informed by Social service director that family member of [Resident 1] had some issues and concern ...The writer followed up and did talk to the nurse schedule am [morning] shift on 4/22/24. The writer called the [Family Member] and explained ...on 4/22/24 resident was attempting to feed self ...without CNA assistance. Due to tremors resident spilled hot cereal over and burn 2 fingers to left hand ...The writer update [sic] ...the son for the new tx [treatment] to apply ...dressing and cover with gauze due to blister already open ... " On 4/26/24 at 5:11 p.m., the LVN 2 documented, "monitoring for left hand boil, no c/o [complaint of] pain or any discomfort, kept clean and dry, will cont. [continue] to monitor. " On 4/27/24 at 2:45 p.m., the LVN 3 documented, "Patient has a wound on left hand on two fingers due to spilling hot cereal over and burned index finger blister measuring apprx [approximately] 2.5x1 and middle finger 2x2 ...Will continue to monitor per order. " On 4/29/24 at 6:07 a.m., the LVN 4 documented, "pt [Patient] cont monitor for boil to l [left] index hand. Dressing is clean dry and intact, no signs of infection noted at this time ... " On 4/29/24 at 2:03 p.m., Registered Nurse 1 (RN	F 642		

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F 642	Continued From page 6 1) documented, " ...No c/o pain or other discomfort. Afebrile [without fever], VSS [vital signs stable]. Wound care completed as ordered by treatment nurse. No s/s [signs and symptoms] of infection noted. " On 4/29/24 at 6:34 p.m., the LVN 5 documented, " ...Pt monitored for left land/finger burned by oatmeal. Pt has bandades [sic] on 2 fingers..Pt skin pink moist mucous membranes ... " On 4/30/24 at 6:52 a.m., the LVN 4 documented, "Pt cont monitor for boil to L [left] index hand. " On 5/17/24 at 4:21 p.m., the LVN 6 documented, "left 2ndand 3rd finger popped blisters have resolved. On 5/19/24 at 8:48 a.m., the LVN 6 documented, "written NP [Nurse Practitioner] updated tx order for left 2nd and 3rd fingers. " There was no documented assessment or evaluation of Resident 1's injuries on the day Resident 1 obtained the injuries to her left hand by an RN, NP or Physician. During a telephone interview on 6/11/24 at 12:40 p.m. with LVN 1, LVN 1 confirmed performing a physical assessment was not within an LVN's scope of practice. The LVN 1 stated assessments are supposed to be completed by the RN. The LVN 1 also stated LVNs cannot diagnose an injury or condition. The LVN 1 stated he was responsible for gathering information of what occurred and providing his findings to the NP or Physician. The LVN 1 verified there was no documented assessment as to the type of burn (first, second or third degree) Resident 1 had received from the hot cereal. During a telephone interview on 6/11/24 at 1 p.m. with the Director of Nursing (DON), the DON	F 642		

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F 642	Continued From page 7 stated, "The RN completes the assessments, it would be expected that the RN would come to the floor and complete the assessment. " A review of the Nursing Practice by the California Nurses Association, undated, stipulates, "The RN is legally responsible for analyzing, synthesizing and evaluating data collected on patients through the RN direct observation ...only the RN can perform assessments, which includes analysis and formulation of a nursing diagnosis ...this responsibility cannot be delegated or assigned to an LVN. " A review of the Vocational Nursing Practice Act, undated, stipulates, "The LVN may use and practice ' basic assessment (data collection)' ...the LVN is required to report and/or refer abnormal values to the RN ...the LVN cannot analyze, synthesize and evaluate data. "	F 642		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		

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F 657	Continued From page 8 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to revise Resident 1's care plan within a timely manner after Resident 1 sustained an injury after an accident. This failure decreased the facility's potential to ensure residents receive appropriate and person-centered care. Findings: A review of Resident 1's admission record indicated Resident 1 was admitted to the facility in May 2020 with diagnoses including parkinsonism (brain conditions that cause tremors) and ataxia (loss of muscle control in arms and/or legs). A review of a nurse progress note dated 4/22/24 at 2:33 p.m. indicated, "[Resident 1] was attempting to feed self this AM [morning] without CNA assistance. Due to tremors [Resident 1] spilled hot cereal over and burn 2 fingers to left hand. Index finger blister measuring apprx [approximately] 2.5x1 ...middle finger 2x2. [Resident 1] was advised to wait for staff to assist	F 657		

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F 657	Continued From page 9 w [with] feeding. NP [Nurse Practitioner] ...wrote new orders to monitor site. " During a review of Resident 1's care plan initiated on 4/26/24 indicated, "[Resident 1] has actual impairment to skin integrity of the left index and middle finger r/t [related to] burn with hot cereal. " During a interview with the Director of Nursing (DON) and concurrent record review on 6/5/24 at 1:45 p.m. of Resident 1's care plan regarding the burns she obtained on 4/22/24, the DON confirmed the care plan had not been revised in a timely manner. The DON stated, "I expect the care plans to be updated the day of or the next day at the latest; this one [care plan] was updated late. " During a review of the facility's policy and procedure (P&P) titled, "Care Plans, Comprehensive Person-Centered, " revised March 2022, indicated, "Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change."	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure physician orders were followed when Resident 1 did not receive wound	F 658		

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F 658	Continued From page 10 care treatment as ordered. This failure decreased the facility's potential to assist Resident 1's wound to heal. Findings: A review of Resident 1's admission record indicated Resident 1 was admitted to the facility on 4/14/24 with diagnoses including open wounds to right and left lower legs, diabetes mellitus (inadequate control of sugar in the blood stream) and atherosclerosis of arteries (narrowing and hardening of the blood vessels) in the legs and feet. During a review of Resident 1's Order Summary Report (OSR, physician orders) printed on 6/5/24, Resident 1 had orders for the following wound care: 1. Starting on 4/15/24, licensed nurses were to monitor Resident 1's left and right lower extremities, lower leg to toes, diabetic foot ulcer for sing or symptoms of infection, every shift. 2. Starting on 4/16/24, licensed nurses were to clean Resident 1's left lower extremity to toes with normal saline, pat dry, paint with betadine (antiseptic used for skin disinfection), cover with abdominal pad (sterile, highly absorbent dressing), wrap in kerlix (fast wicking and absorbent) dressing daily, or as needed due to multiple injuries. 3. Starting on 4/22/24, licensed nurses were to clean Resident 1's right lower extremity to toes with normal saline, pat dry, paint with betadine (antiseptic used for skin disinfection), cover with	F 658		

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F 658	Continued From page 11 abdominal pad (sterile, highly absorbent dressing), wrap in kerlix (fast wicking and absorbent) dressing daily, or as needed due to multiple injuries. A review of Resident 1's Treatment Administration Record (TAR), dated April 2024, indicated the following: 1. There was no documented evidence of monitoring of Resident 1's left and right lower extremities for 20 out of 70 shifts. On the morning shift on 4/18/24 and 4/24/24 staff documented a "9 " on the treatment record. A review of the TAR chart codes indicated a "9 " represented, "Other, See Progress Notes. " A review of Resident 1's progress notes dated 4/18/24 and 4/24/24 indicated no reason why the monitoring was not completed. 2. There was no documented evidence wound treatment was conducted on Resident 1's left lower extremity to toes for 5 out of 11 shifts. On 4/18/24 and 4/24/24 a "9 " was annotated on the TAR. A review of Resident 1's progress notes dated 4/18/24 and 4/24/24 indicated no reason why the wound treatment was not conducted. 3. There was no documented evidence wound care treatment was conducted on Resident 1's right lower extremity to toes for 3 out of 5 shifts. On 4/18/24 a "9 " was annotated on the TAR. A review of Resident 1's progress notes dated 4/18/24 indicated no reason why the wound treatment was not conducted. On 6/5/24, a review of a skin observation tool, dated 4/18/24 (four days after Resident 1's admission), was reviewed. The document	F 658		

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F 658	Continued From page 12 indicated Resident 1 had a right lower leg diabetic ulcer (a serious complication caused by a combination of poor circulation, susceptibility to infection and nerve damage from high blood sugar levels) which measured 9.5 cm (centimeters, a unit of measurement) by 3 cm and a left lower leg diabetic ulcer which measured 15.5 cm by 4 cm. During a concurrent interview and record review on 6/5/24 at 11:42 a.m. with Licensed Nurse 1 (LN 1), the LN 1 confirmed the missing dates on Resident 1's April 2024 TAR and stated, "The empty dates on the TAR either indicate the treatment wasn't done or maybe the nurse forgot to check it off ...either way, there is no documentation to verify if the treatment was done. " The LN 1 verified there were no progress notes written in Resident 1's chart to indicate why the treatments were not completed. During a review of Resident 1's records on 6/5/24 at 2:03 p.m., Resident 1's admission skin assessment was requested. The facility failed to provide the surveyor with a copy of Resident 1's admission skin assessment. During a concurrent interview and record review on 6/5/24 at 3:40 p.m. with the Director of Nursing (DON), the DON confirmed there were missing and blank dates on Resident 1's April 2024 TAR. The DON stated, "The nurse either didn't do the treatment or they didn't initial that they did it, I'm unable to determine if the treatment had been completed or not. " The DON explained a "9 " on the TAR indicated the treatment was not done and there should be a progress note associated with the specific date; the DON confirmed there were no progress notes in Resident 1's chart to	F 658		

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F 658	Continued From page 13 indicate why treatments were not completed. A review of the facility's policy and procedure (P&P) titled, "Charting and Documentation, " revised July 2017, indicated, "All services provided to the resident ...shall be documented in the resident's medical record ...The following information is to be documented in the resident medical record ...Treatments or services performed. Documentation in the medical record will be ...complete, and accurate. " A request for the facility's P&P regarding the standard for following physician orders was requested on 6/11/24 at 3:53 p.m. The facility was not able to provide an appropriate P&P. A review of the California Nursing Act indicated licensed nurses have a legal duty to carry out physician's orders as written.	F 658		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review the facility failed to ensure the safety for one resident (Resident 1) when Resident 1 did not receive adequate supervision and assistance during breakfast.	F 689		

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F 689	Continued From page 14 This failure resulted in burns and blisters to two of Resident 1's fingers and pain to the affected area. Findings: A review of Resident 1's admission record indicated Resident 1 was admitted to the facility in May 2020 with diagnoses which included parkinsonism (brain conditions that cause tremors) and ataxia (loss of muscle control in arms and/or legs). A review of a nurse progress note dated 4/22/24 at 2:33 p.m. indicated, "[Resident 1] was attempting to feed self this AM [morning] without CNA assistance. Due to tremors [Resident 1] spilled hot cereal over and burn 2 fingers to left hand. Index finger blister measuring apprx [approximately] 2.5x1 ...middle finger 2x2. [Resident 1] was advised to wait for staff to assist w [with] feeding. NP [Nurse Practitioner] ...wrote new orders to monitor site. " During a concurrent observation and interview on 6/5/24 at 9:50 a.m. with Resident 1, in Resident 1's room, Resident 1 was observed sitting up in bed, with tremors noted to her right hand. Resident 1 stated she needed assistance with eating due to her tremors because she was not able to hold the utensils steady. Resident 1 stated the Certified Nursing Assistant 1 (CNA 1) was assisting her the day of the incident and had taken the hot cereal to heat it in the microwave. When the CNA 1 returned with the hot cereal, Resident 1 stated the CNA 1 then stepped away from the bedside. Resident 1 stated she picked up her fork to check the temperature of the hot cereal, brought the hot cereal to her lips, dropped the fork because the cereal was so hot, the hot	F 689		

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F 689	Continued From page 15 cereal spilled on her left hand and the bowl fell to the floor. Resident 1 stated, "I screamed bloody murder, it was the most painful thing. I let out a blood curdling yell, but I don't think staff took it seriously. The charge RN (Registered Nurse) never came to evaluate me or the wound nurse until a few days later. " During an interview on 6/5/24 at 10:22 a.m. with CNA 1, the CNA 1 stated she was not familiar with Resident 1's care, although she did know Resident 1 needed assistance with her meals. On the day of the incident, it was the second time CNA 1 had been assigned to care for Resident 1. The CNA 1 stated she microwaved Resident 1's hot cereal that morning. The CNA 1 stated, "I put the cereal in the microwave and set the timer for one minute, but I took it out before the timer went off. I admit it, it was my fault, it was probably too hot. " The CNA 1 stated she placed the hot cereal on Resident 1's tray and then stepped away, approximately four feet, behind the curtain to get Resident 1's coffee. Resident 1 yelled out and CNA 1 turned back around to check on Resident 1. The CNA 1 stepped around the curtain and noticed Resident 1's left hand between the third and fourth fingers were red. The CNA 1 stated she reported the incident immediately to the Licensed Vocational Nurse 1 (LVN 1). The CNA 1 stated, "I assumed she would wait to let me help her with the cereal, I'm supposed to help her. She [Resident 1] was screaming, I noticed her hand immediately, her fingers blistered between one to two hours after [the spill]. " During an observation on 6/5/24 at 11:35 a.m. the microwave across from the nursing station on "D " unit was observed. Taped to the top of the	F 689		

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F 689	Continued From page 16	F 689		

microwave was a laminated sign which stated, "Re-Warming Liquids, Temperature Should Not Exceed 145 Degrees. Test all liquids with a thermometer before giving to your resident/patient. " To the left of the microwave a digital thermometer was hanging in a black pouch on the wall. A cup from the kitchen with approximately 1.5 in (inches, a unit of measure) of water was placed inside the microwave and the microwave was set to one minute. At 41 seconds the cup, which did not feel hot, was removed from the microwave. The thermometer was placed into the cup of water and was held in place for 15 seconds. When the thermometer was removed the temperature on the thermometer read 166.4 degrees Fahrenheit (F, a unit of measurement).

During an interview on 6/5/24 at 12:05 p.m. with CNA 2, the CNA 2 stated, "There's a thermometer in there [room next to nursing station] but I don't use it. The cereals in the morning are already nice and warm, there's no reason to reheat them. "

During an interview on 6/5/24 at 12:43 p.m. with CNA 3, the CNA 3 stated, "Resident 1 will end up spilling her food because she shakes, she gets food everywhere, we [CNAs] have to assist her. " CNA 3 stated Resident 1 attempts to use her spoon or fork, but she shakes and the food drops everywhere.

During a concurrent observation and interview on 6/5/24 at 12:57 p.m. with CNA 2 and CNA 3 (CNA 1 was unavailable) the microwave and thermometer was observed. The CNA 2 and CNA 3 confirmed they were aware of the sign and the thermometer, and they have received education "in the past " on how to use the microwave and

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F 689	Continued From page 17 thermometer. During an interview on 6/5/24 at 1:45 p.m. with the Director of Nursing (DON), the DON confirmed CNA 1 should not have left Resident 1 unattended during breakfast. The DON stated Resident 1 needed assistance and supervision with meals, she has tremors and is unable to feed herself. A review of the facility's policy and procedure (P&P) titled, "Safety and Supervision of Residents, " revised July 2017, the P&P indicated, "Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. "	F 689		