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 07/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESKATON CARE CENTER FAIR OAKS	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 #CA00843078. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 32096 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	F 000	POC Rec'd 7/20/23 POC approved 7/24/23 BIC 7/14/23	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		

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

Director of Nursing Services 7/11/2023

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.

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F 000	INITIAL COMMENTS *AMENDED* The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of complaint #CA00843078. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 32096 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		

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

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.

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F 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a person-centered care plan for one of three sampled residents (Resident 1) when the facility identified that the resident developed skin care needs and refused bathing. This failure resulted in Resident 1 not having clear care guidelines to the desired health outcomes of the identified issues and had the potential for the resident having unmet care needs. Findings:	F 656		

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F 656	Continued From page 2 Resident 1 was a long-term resident in the facility with comorbidities which included diabetes, lung problems, heart failure, moisture related skin issues due to incontinence and advanced age. Review of the most recent MDS (Minimum Data Set, an assessment tool) indicated Resident 1 was cognitively intact, bed bound and required assistance with bathing and activities of daily living. Review of the facility's policy and procedure, revised 10/27/22, stipulated, "A Care Plan will be developed to meet the identified needs of the resident...The licensed nurse will document the status of each skin impairment and response in the Health Record and update the plan of care as needed." Review of Resident 1's clinical record indicated there was no care plan for the identified feet fungal issue. In a telephone interview on 7/3/23 starting at 10 a.m., with Licensed Nurse (LN) 1 present, the Director of Nursing (DON) stated Resident 1 had the fungal issue to her feet and it had been treated. The DON verified there was no care plan developed for the fungal problem and acknowledged there should have been a care plan for the feet issues as stipulated in the facility's policy and procedure. 2. In an interview on 6/6/23 at 12:17 p.m., Certified Nurse Assistant (CNA) 1 stated Resident 1 refused bed baths. CNA 1 stated CNAs checked residents skin integrity whenever they gave shower or bed bath to residents.	F 656		

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F 656	Continued From page 3 In an interview on 6/6/23 at 12:23 p.m., CNA 2 stated Resident 1's shower days were in the AM on Thursdays and Sundays. CNA 2 stated Resident 1 refused bed baths. In an interview on 6/6/23 at 1:30 p.m., the Nurse Practitioner (NP) stated she was aware that Resident 1 refused to get out of bed and refused taking a bed bath. Review of Resident 1's clinical record, MAR (Medication Administration Record)/TAR (Treatment Administration Record) for March and April 2023 indicated Resident 1 had a physician order, dated 6/20/22, for LNs to document the resident's refusal for shower and bed bath. The MAR/TAR indicated Resident 1's shower days were Thursdays and Sundays and documented the resident received a bed bath once on 3/9/23 in March 2023 and had no bed bath in April 2023. Review of the facility's 10/26/12 policy and procedure, Care Plan Process, stipulated, "The comprehensive care plan has been designed to...Incorporate identified problem areas;..Prevent declines in the resident's functional status and/or functional levels..." In a telephone interview on 6/27/23 at 1:27 p.m., the DON stated the facility identified Resident 1 was non-compliant with personal care and notified the physician back in June 2022. The DON stated the physician then ordered for LNs to document Resident 1's refusal for bed bath in the MAR. The DON stated Resident 1 was non-compliant with bed baths for a long time and it should have been care planed.	F 656		

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F 684	Continued From page 4	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the care and treatment needed for one of three sampled residents (Resident 1) when Resident 1's skin issues were unnoted by staff. This failure resulted in Resident 1 sustaining two open areas of odorous wounds with exudate (fluid that leaks out of blood vessels into nearby tissues) under her left arm pit, 100% red tissue in her left upper chest, and mid upper back with exudate: Findings: Resident 1 was a long-term resident in the facility with comorbidities which included diabetes, lung problems, heart failure, moisture related skin issues due to incontinence and advanced age. Review of the most recent MDS (Minimum Data Set, an assessment tool) indicated Resident 1 was cognitively intact, bed bound and required assistance with bathing and activities of daily living.	F 684		

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F 684	Continued From page 5 In a telephone interview on 6/6/23 at 8:56 a.m., Resident 1's Representative (RR), the Power of Attorney for the resident, stated the facility transferred Resident 1 to a hospital emergency room (ER) on 4/17/23 due to her slow heart rate and the resident was subsequently admitted to the hospital; Upon admission to the hospital floor, the RR was informed that Resident 1 had several skin wounds that she was not aware of. The RR stated she was shocked when she saw the resident wounds that were "rotting" and there were "holes" under the resident's arm pit. The RR stated the hospital doctor said that the resident had the skin condition "for a quite a while." The RR voiced the facility should have identified and treated the resident's skin issues before they went "so bad" and stated it was "pure neglect" that the facility did not treat the resident's "rotten" skin condition. Review of Resident 1's medical record, "Resident Progress Note " dated 4/17/23; indicated Resident 1 was sent to a general acute care hospital ER at about 10:40 a.m., that morning due to a change in condition, having shortness of breath with increased respiration rate of 25-30/minute (adult person normal at 12-20/ minute) and heart rate of 40-46/minute (adult person normal at 60-100/minute). Review of the hospital provided "Wound Care Note " for Resident 1, dated, and timed 4/18/23 at 12:42 p.m., described the resident skin wounds with pictures of the affected areas as follows: 1. Left upper chest: 2.5 cm (centimeter) x 2.8 cm (1" x 1.1"); 100% red tissue with dry peeling tissue and had scant serosanguineous (contains	F 684		

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F 684	Continued From page 6 or related to both blood and the liquid part of blood) exudate 2. Left arm axilla (armpit): 10 cm x 10 cm (3.9" x 3.9"); Two open areas under armpit with dark red tissue and dry patchy peeling tissue with swelling and mild odor with small amount of serosanguineous exudate 3. Mid upper back: 4 cm x 5 cm (1.6" x 2"): 100 % red tissue intact maroon discoloration with scant serosanguineous exudate In addition to the wound's description, this Wound Care Note included the "current treatment" with "Treatment Recommendation," and "PRESSURE INJURY PREVENTION MEASURES" that was attested by the wound doctor (MD 1). In an interview on 6/6/23 at 11:57 a.m., Licensed Nurse (LN 1), who used to be the treatment nurse, stated Resident 1 was transferred to the hospital due to a total heart block on 4/17/23 and returned to the facility on 4/29/23 with hospice care and expired on 5/1/23. LN 1 stated Resident 1 had a long history of skin issues that had been treated but the facility did not know of any open wounds under her armpit or other skin issues except her fungal left arm, hand and her bilateral feet that had been treated with an anti-fungal cream. LN 1 explained it was the facility policy that Certified Nurse Assistants (CNAs) were to check residents' skin integrity during the shower or bed bath using the shower sheet and to report to LNs if any new skin issues were noted. LN 1 stated all residents received shower or bed baths twice a week minimum and the facility kept all shower sheets including the days when residents refused to shower. LN 1 stated CNAs did not	F 684		

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F 684	Continued From page 7 report any skin issues for Resident 1. In an interview on 6/6/23 at 12:17 p.m., CNA 1 stated Resident 1 refused bed baths. CNA 1 stated CNAs checked residents' skin whenever they gave a shower or a bed bath to residents. In an interview on 6/6/23 at 12:23 p.m., CNA 2 stated Resident 1's shower days were in the AM on Thursdays and Sundays. CNA 2 stated Resident 1 refused bed baths. In an interview on 6/6/23 at 12:59 p.m., LN 2 stated she was the medication nurse, not a treatment nurse, and stated she was not sure Resident 1 had any skin issues. Review of the facility's policy and procedure, revised 10/27/22, Skin Integrity Protocol, stipulated residents were evaluated to identify current skin impairment as well as their potential risk of skin impairment. As an ongoing evaluation, the policy instructed CNAs to observe for any skin issues during routine episodes of care, and on the shower day and to report to the licensed nurse any new areas of skin concerns using, the "Shower Day Skin Inspection worksheet...Resident's skin will be inspected using the shower sheet even if the shower is refused." Shower Day Skin Inspection worksheets for March and April 2023 requested and the facility provided a total of 6 shower sheets including February 2023 as follows: 2/5/23: Refused 2/16/23: Refused	F 684		

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F 684	Continued From page 8 2/23/23: Refused 3/9/23: Bed bath 3/30/23: Refused 4/16/23: Refused There were 14 shower days for the resident from March 1, 2023, to April 17, 2023 before she was transferred to the ER and it was documented that the resident had one bed bath out of the 14 shower days scheduled in March and April 2023. In an interview on 6/6/23 at 1:22 p.m., the Director of Nursing (DON) indicated the facility was not aware of the resident wounds on her armpit and stated the resident's skin issues had not been brought up during the daily stand-up meeting when staff discussed any care issues. The DON stated he was informed that Resident 1 was treated for shingles (a viral infection that painful rash develops on one side of the face or body) in the hospital and mentioned the possibility that the resident's skin issues could have developed within hours upon the hospital transfer. In an interview on 6/6/23 at 1:30 p.m., the Nurse Practitioner (NP) stated Resident 1 had a history of dermatitis longer than 10 years and was fragile with compromised health. The NP stated she saw the resident's wound pictures taken from the hospital and stated the wound under the resident's armpit appeared to be macerated (skin breakdown due to moisture). The NP indicated the wound under her armpit could have been developed within hours if the resident was sweating profusely; however, the NP clarified the	F 684		

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F 684	Continued From page 9 armpit was not a dermatome (nerve connections on the spine) for shingles. The NP stated the wound should have been identified. Review of Resident 1's clinical records, Resident Progress Notes, did not indicate the resident was sweating profusely on 4/17/23. Review of the hospital ER physician note, dated 4/17/23, and the review of the hospital Wound Care Note for Resident 1, dated 4/18/23, did not indicate the resident sweated excessively. In a telephone interview on 6/27/23 at 1:21 p.m., the Director of Nursing (DON) stated the six shower sheets were, "all we can find", and explained the shower sheets were worksheets that CNAs used, and they were not a part of residents' medical records; therefore, they were not required to be kept. The DON stated the facility had no specific guidelines how long the shower sheets are to be kept before discarding them. The DON acknowledged the resident had one bed bath on 3/9/23 during March and April 2023. In a telephone interview on 7/3/23 starting at 10 a.m., with LN 1 present, the DON verified the resident was transferred to the hospital on 4/17/23 because of heart block, not because of shingles.	F 684		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F 842		

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F 842	Continued From page 10 resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F 842		

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F 842	Continued From page 11 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1's) clinical records were accurate when the MDS (Minimum Data Set, an assessment tool) and a Licensed Nurse (LN) weekly summary for the resident was inconsistent with the MAR (Medication Administration Record) for a census of 125. This failure resulted in Resident 1's skin issues not to have been correctly reflected in the medical records and had the potential for misleading health professionals in making treatment decisions for the resident. Findings:	F 842		

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 07/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESKATON CARE CENTER FAIR OAKS	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 842	Continued From page 12 Resident 1 was a long-term resident in the facility with comorbidities which included diabetes, lung problems, heart failure, moisture related skin issues due to incontinence and advanced age. Review of the most recent MDS (Minimum Data Set, an assessment tool) indicated Resident 1 was cognitively intact, bed bound and required assistance with bathing and activities of daily living. Review of Resident 1's clinical record, the Medication Administration Records (MAR), included a physician order, dated 4/23/21, for terbinafine cream 1% (a prescription medication, an anti-fungal medication) to apply both resident's feet for fungus twice a day. In an interview on 6/6/23 at 11:57 a.m., Licensed Nurse (LN 1), who used to be the treatment nurse, stated Resident 1 had fungal issues to her left arm, hand and bilateral feet for more than 6 months and she administered terbinafine to the resident's feet. Review of Resident 1's clinical record, the most recent MDS, dated 3/16/23, indicated the resident did not have any foot problems in the Skin Section of the MDS. There was an "X" mark next to "None of the above were present" indicating the resident did not have any infection, diabetic foot ulcers or other open lesion on the foot. Review of LN's weekly summary, dated 4/16/23, for Resident 1, indicated the resident had no skin issues other than the resident's skin condition was "Dry" and "Fragile".	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 13 In a telephone interview on 7/5/23 at 1:22 p.m., the Director of Nursing (DON) verified the inconsistent documentation regarding the resident's skin issues to her feet. The DON acknowledged the inaccurate and the inconsistent documentation could have mis-led the health care professionals in making treatment decisions for the resident.	F 842		

F 684 Quality of Care: #CA00843078

§ 483.25 Quality of care: Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

The following narrative represents Eskaton Fair Oaks response to complaint #CA00843078 and our intentions to correct associated problems.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Education will be provided to CNA, LVN, & RN staff to ensure a recent and clear understanding of policy surrounding skin integrity protocols, skin integrity documentation guidelines, and change of condition expectations. The policies and protocols clearly provide expectations surrounding the CNA skin inspection and reporting to LVN or RN, completing skin inspection even if resident refuses a bath/shower, assessment of all residents, reporting of findings and to who, reporting change of condition, acquiring an MD order for the change, providing treatment in accordance of the MD order, and placing the comprehensive person centered care plan into action that represents the resident's choices. Education will include narrative with clear expectations including policy and protocols and resulting discussion.

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; an audit will be conducted on each A-wing resident to ensure a skin assessment is completed in accordance with policy on each resident, that all change of condition are managed in accordance with policy, and the comprehensive care plan is in place for any resident with a wound to establish a baseline. 10 residents / patients from each of other 3 units will receive audits to establish a baseline on those units and ensure this problem is isolated to the A-wing. Any identified problems will be corrected.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Discussion surrounding policy and procedures and resulting expectations will continue during shift change huddles 7 days per week, for one week each month for six months to ensure staff understand the "why" behind completing a skin assessment in accordance with policy on each resident, that all change of condition are managed in accordance with policy, and the comprehensive care plan is in place for any resident with a wound. If 100% of resident / patient audits are not met with the proper care plan in place, then this process will continue for a full month. During the next 1 month, 10 chart audits per week will be completed. Random audits will continue on all units during the 3rd month to monitor compliance. Process will be continued until 95% compliance maintained.

How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and: Data from audits will be reported to the nurse driven monthly meetings and reviewed for compliance or if further mitigation plans need to be placed into action. Data will further be moved to the quarterly QAPI meetings and discussed as team. QAPI data will be reported to all staff to view and progress will be discussed through huddle process to ensure staff see the results of their work.

Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency. POC will be implemented on beginning 07/14/2023 and completed 07/28/2023. Copies of sign-in sheets completed to date are included with this POC. Completed copies will be maintained on site and reported up through our QAPI process.

F 842 Resident Records - Identifiable Information #CA00843078

§483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes;

The facility failed to ensure Resident 1's clinical records were accurate when the MDS and a Licensed Nurse weekly summary for the resident was inconsistent with the MAR for a census of 125.

The following narrative represents Eskaton Fair Oaks response to complaint #CA00835698 and our intentions to correct associated problems.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Education will be provided to LVN, & RN staff to ensure a recent and clear understanding of policy / protocol for a complete and accurate Weekly Summary that accurately aligns with current MD orders and resulting treatments. Education will include narrative surrounding policy and procedures and resulting discussion..

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; an audit will be conducted on each A-wing resident to ensure a care plan is in place for any resident with a wound to establish a baseline. 10 residents / patients from each of other 3 units will receive audits to establish a baseline on those units and ensure this problem is isolated to the A-wing. Any identified problems will be corrected.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Discussion surrounding policy and protocol with resulting expectations will continue during shift change huddles 7 days per week, for one week each month for six months to ensure staff understand the "why" behind an accurate and complete Weekly Summary which accurately aligns with current MD orders and resulting treatments. If 100% of resident / patient audits are not met with the proper care plan in place, then this process will continue for a full month. During the next 1 month, 10 chart audits per week will be completed. Random audits will continue on all units during the 3rd month to monitor compliance. Process will be continued until 95% compliance maintained.

How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and: Data from audits will be reported to the nurse driven monthly meetings and reviewed for compliance or if further mitigation plans need to be placed into action. Data will further be moved to the quarterly QAPI meetings and discussed as team. QAPI data will be reported to all staff to view and progress will be discussed through huddle process to ensure staff see the results of their work.

Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency. POC will be implemented on beginning 07/14/2023 and completed 07/28/2023. Copies of sign-in sheets completed to date are included with this POC. Completed copies will be maintained on site and reported up through our QAPI process.

F 656 Develop/Implement Comprehensive Care Plan: #CA00843078

§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident.

The following narrative represents Eskaton Fair Oaks response to complaint #CA00843078 and our intentions to correct associated problems.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Education will be provided to CNA, LVN, & RN staff to ensure a recent and clear understanding of policy of care plan expectations surrounding the implementation of the comprehensive person-centered care plan for each resident. Education will include narrative surrounding policy and procedures and resulting discussion.

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; an audit will be conducted on each A-wing resident to ensure a care plan is in place for any resident with a wound to establish a baseline. Ten residents / patients from each of other 3 units will receive audits to establish a baseline on those units and ensure this problem is isolated to the A-wing. Any identified problems will be corrected.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Discussion surrounding policy and procedures and resulting expectations will continue during shift change huddles 7 days per week, for one week each month for six months to ensure staff understand the "why" behind a patient centric care plan. If 100% of resident / patient audits are not met with the proper care plan in place, then this process will continue for a full month. During the next 1 month, 10 chart audits per week will be completed. Random audits will continue on all units during the 3rd month to monitor compliance. Process will be continued until a minimum of 95% compliance maintained.

How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and: Data from audits will be reported to the nurse driven monthly QAPI meetings and reviewed for compliance or if further mitigation plans need to be placed into action. Data will further be moved to the quarterly QAPI meetings and discussed as team. QAPI data will be reported to all staff to view and progress will be discussed through huddle process to ensure staff see the results of their work.

Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency. POC will be implemented on beginning 07/14/2023 and completed 07/28/2023. Copies of sign-in sheets completed to date are included with this POC. Completed copies will be maintained on site and reported up through our QAPI process.