STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055092	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yuba City Post Acute	1220 Plumas St Yuba City, CA 95991

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on interview and record review, the facility failed to report an allegation of abuse to local, state, and federal agencies, including the California Department of Public Health (CDPH), when Certified Nurse Assistant (CNA) E stated, CNA E observed Resident 48 shaking a fist and making verbal threats to harm Resident 50. This failure placed all residents at risk for allegations of abuse to go unreported. Findings: A review of the facility's policy and procedure (P&P) titled, Abuse Investigation and Reporting, revised 7/1/17, indicated, reports of alleged abuse would be reported to local, state, and federal agencies. A review of the facility's P&P titled, Abuse Prevention Program, revised 2/1/24, indicated, residents had the right to be free from abuse. A review of the State Operation Manual, revised 8/8/24, defined abuse as a willful infliction that included verbal abuse or intimidation, which could affect a person's psychosocial well-being. A review of the undated Admission Record, indicated, Resident 48 was admitted to the facility on [DATE] with the diagnoses of muscle weakness, difficulty in walking, and major depressive disorder, single episode, with psychotic features (A distinct type of depression that could cause hallucinations or delusion while in a depressive episode). Resident 48 was not his own responsible party (RP) and had a public guardian that made decisions for him. A review of Resident 48's Minimum Data Set (MDS, an assessment tool), Section C-Cognitive Patterns, (a memory assessment), dated 7/31/24, indicated, Resident 48's cognition was moderately impaired (decline in memory, thinking, and judgement). A review of Resident 50's undated Admission Record, indicated, admission to the facility on [DATE] with the diagnoses of Alzheimer's disease (inability to remember), anxiety (feelings of fear and dread), depression, and obsessive-compulsive disorder (uncontrolled and recurring thoughts, repetitive behaviors, or both), and was on hospice (six months or less left to live and received care focused on comfort). Resident 50 was not his own RP and did not make his own decisions. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024

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Yuba City Post Acute	1220 Plumas St Yuba City, CA 95991

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 50's MDS, Section C-Cognitive Patterns, dated 7/16/24, indicated, Resident 50 had severe cognitive impairment. Section E-Behavior, dated 7/23/24, indicated, Resident 50 wandered (roamed from place to place), and Resident 50's wandering did not intrude on the privacy or activities of others. During an interview on 8/28/24 at 8:04 a.m., Resident 48 stated, Resident 50, who was Resident 48's roommate, would come over to Resident 48's side of the room and touch Resident 48's arm and has been doing so since Resident 50 was admitted to the facility. Resident 48 stated, telling facility staff about Resident 50's behaviors and facility staff had not done anything about it. Resident 48 stated, not liking Resident 50 touching him. Resident 48 stated, the facility better do something soon though, I'm going to hurt him. During an interview on 8/28/24 at 2:50 p.m., CNA E confirmed, Residents 48 and 50 were roommates. CNA E stated, Resident 48 and Resident 50 did not like each other. CNA E stated, on 8/27/24, Resident 48 tried to get into Resident 50's face, used a fist, and threatened to hit Resident 50. CNA E stated the incident was reported to Licensed Nurse (LN) A. During an interview on 8/28/24 at 2:57 p.m., CNA F stated, on 8/27/24 at approximately 2:45 p.m., CNA F was transferring Resident 48 into bed from the wheelchair. CNA F stated, during the transfer, Resident 50 had a smile on his face and was waving at Resident 48. CNA F stated, Resident 48 got mad and tried to walk over to Resident 50. CNA confirmed, Resident 48 made a verbal threat to Resident 50 that involved physical abuse. CNA F stated, she reported the incident to LN A. During an interview on 8/28/24 at 3:04 pm, LN A confirmed, there was an incident between Resident 48 and Resident 50 that occurred on 8/27/24. LN A stated, she was told Resident 48 had a fist pulled up as if he was going to hit Resident 50. LN A stated, reporting the incident the Director of Nursing (DON). During an interview on 8/29/24 at 10:20 a.m., DON stated, facility staff did not notify DON of the incident between Residents 48 and 50 that had occurred on 8/27/24. DON stated, not being notified until CDPH staff brought it to DON's attention. DON stated, staff expectancy for allegations of abuse included notifying the DON. DON stated, the DON would then report the allegation of abuse to the abuse coordinator who was the facility's Administrator. DON confirmed, the allegation of abuse was not reported to local, state, and federal agencies, including CDPH.

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NAME OF PROVIDER OR SUPPLIER Yuba City Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1220 Plumas St Yuba City, CA 95991	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on interview and record review, the facility failed to revise care plans (a document that described health conditions, the level of care the resident required, and how that care would be provided) for two out of two sampled residents (Residents 34 and 50) when: 1. Resident 34's care plan was not revised to include wandering behaviors (roaming from place to place). 2. Resident 50's care plan was not revised to include a change in wandering behaviors. This failure had the potential to cause a decline in physical, mental, and psychosocial well-being and placed Residents 34 and 50 at risk for harm. Findings: 1. A review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive, indicated, the care plan would Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The P&P indicated, the care plan would Incorporate identified problem areas and that care plans would be revised when resident information changed. A review of Resident 34's undated Admission Record, indicated, admission to the facility on [DATE] with the diagnoses of seizures (uncontrollable shaking of the body) and down syndrome (a genetic condition that changed how the body and brain developed). Resident 34 was not his own responsible party (RP, did not make own decisions about care). A review of Resident 34's Minimum Data Set (MDS, an assessment tool) dated 8/7/24, indicated, Resident 34 did not wander. A review of Resident 34's care plans, dated 8/3/24 through 8/23/24, indicated, there was no care plan in place for Resident 34's wandering behavior. A review of Resident 46's MDS, dated [DATE], indicated Resident 46 was admitted to the facility on [DATE] with the diagnosis of a multidrug-resistant organism (in infection that many antibiotics did not cure). The MDS indicated, Resident 46 had good cognition (ability to remember and think). During an interview on 8/27/24 at 10:45 a.m., Resident 46 stated, Resident 34 often wandered into Resident 46's room. During an interview on 8/27/24 at 11:27 a.m., Resident 267 stated, Resident 34 would wander into Resident 267's room. Resident 267 stated, facility staff would have to remove Resident 34 from the room, and sometimes, it bothered Resident 267. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 35's MDS, dated [DATE], indicated, Resident 35 was admitted to the facility on [DATE] with the diagnoses of anxiety and depression. The MDS indicated, Resident 35 had good cognition. During an interview on 8/27/24 at 11:39 a.m., Resident 35 stated, Resident 34 wandered into Resident 35's room and Resident 35 would have to tell Resident 34 to leave. 2. A review of Resident 50's undated Admission Record, indicated, admission to the facility on [DATE], with the diagnoses of Alzheimer's disease (inability to remember), anxiety (feelings of fear and dread), depression, and obsessive-compulsive disorder (uncontrolled and recurring thoughts, repetitive behaviors, or both), and was a hospice resident (six months or less left to live and received care focused on comfort). Resident 50 was not his own RP and did not make his own decisions. A review of Resident 50's MDS, dated [DATE], indicated, Resident 50 had severe cognitive impairment, wandered, and wandering did not intrude on the privacy or activities of others. A review of Resident 50's care plan titled, Elopement, dated 7/10/24, did not indicate Resident 50 wandered into other resident rooms. During an interview on 8/27/24 at 11:27 a.m., Resident 267 stated, Resident 50 would wander into Resident 267's room. Resident 267 stated, facility staff would have to remove Resident 50 from the room, and sometimes, it bothered Resident 267. During an interview on 8/28/24 at 8:04 a.m., Resident 48 stated, Resident 50 was his roommate and Resident 50 would wander into Resident 48's side of the room and touch Resident 48's arm. Resident 48 stated, reporting Resident 50's wandering behavior to staff in the past and nothing had been done about it. Resident 48 stated, he did not like it when Resident 50 did that and if staff did not do something about it, Resident 48 would hurt Resident 50. During an interview on 8/28/24 at 2:50 p.m., CNA E confirmed, Residents 34 and 50 wandered into other resident rooms. CNA E stated, awareness that there were issues between Resident 48 and his roommate Resident 50 and in the past, Resident 48 had made verbal threats to hurt Resident 50. CNA E was asked about care plans and interventions that were in place regarding Residents 34 and 50 wandering into other resident rooms. CNA E stated, unawareness of care plans or interventions. During an interview on 8/28/24 at 2:57 p.m., CNA F confirmed, Residents 34 and 50 wandered the facility. CNA F confirmed, Resident 34 wandered into other resident rooms and required redirection. During an interview on 8/27/24 at 3:04 p.m., Licensed Nurse A confirmed, Resident 34 and Resident 50's wandering behaviors and stated the Director or Nursing (DON) had been notified. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/29/24 at 10:20 a.m., with the facility's DON, the care plans for Resident 34 were reviewed. DON confirmed, there was no care plan in place for Resident 34's wandering behaviors. DON stated, having no awareness that Resident 34 wandered into other resident rooms and staff should have reported that information to her. DON stated, Resident 50 wandered the facility but had no awareness that Resident 50 wandered into other resident rooms. Resident 50's care plan titled, Elopement, dated 7/10/24 was reviewed. DON confirmed, there were no interventions in place for Resident 50 regarding wandering into other resident rooms. DON stated the expectancy was for staff to notify the DON when there were changes with residents so the DON could assess the resident and revise the care plan as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to provide adequate supervision based on individual resident needs, for three out of three sampled residents (Residents 34, 50, and 28) when: 1. Facility staff was aware Resident 34 wandered (roamed from place to place) in and out of other resident rooms. 2. Facility staff was aware Resident 50 wandered in and out of other resident rooms. 3. Facility staff was aware that Resident 28 demonstrated daily episodes of increased agitation and volatility exhibited by yelling, cursing, and throwing items. This failure had the potential to impact resident safety, privacy, dignity, and placed residents at an increased risk for resident-to-resident altercations. Findings: 1. A review of the facility's policy and procedure (P&P) titled, Wandering and Elopement, revised 10/1/23, indicated, the facility staff would identify residents who were at risk for unsafe wandering and develop a plan to keep the residents safe. A review of the Resident [NAME] of Rights, dated 12/1/12, indicated, the residents of the facility had the right to respect, dignity, and privacy. A review of Resident 34's undated Admission Record, indicated, admission to the facility on [DATE] with the diagnoses of seizures (uncontrollable shaking of the body), down syndrome (a genetic condition that changed how the body and brain developed), and developmental disorder of speech and language (difficulty with language and understanding what was said to them, may not be able to speak verbally or communicate with hand gestures). Resident 34 was not his own responsible party (RP, person that made decisions about care). A review of Resident 34's Minimum Data Set (MDS, an assessment tool) dated 8/7/24, indicated, Resident 34 did not wander and had difficulty understanding and speaking. A review of Resident 34's care plan (a document that described health or behavioral concerns, what care was needed, and how staff would deliver care) dated 8/4/24, indicated, there was no care plan in place for Resident 34's wandering behavior. A review of Resident 46's MDS, dated [DATE], indicated Resident 46 was admitted to the facility on [DATE] with the diagnosis of a multidrug-resistant organism (in infection that many antibiotics would not cure). The MDS indicated, Resident 46 had good cognition (ability to remember and think). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/27/24 at 10:45 a.m., Resident 46 stated, Resident 34 often wandered into Resident 46's room. During an interview on 8/27/24 at 11:27 a.m., Resident 267 stated, sometimes Resident 267 was bothered by Resident 34 wandering into Resident 267's room and that facility staff would have to remove Resident 34. A review of Resident 35's MDS, dated [DATE], indicated, Resident 35 was admitted to the facility on [DATE] with the diagnoses of anxiety and depression. The MDS indicated, Resident 35 had good cognition. During an interview on 8/27/24 at 11:39 a.m., Resident 35 stated, Resident 34 would wander into Resident 35's room and Resident 35 had to tell Resident 34 to leave. A review of Resident 57's undated Admission Record, indicated, Resident 57 was admitted to the facility on [DATE] with the diagnoses of depression and a fracture to the shaft of the left tibia (the large bone in the lower leg, just below the knee joint). A review of Resident 57's MDS, dated [DATE], indicated, Resident 57 had good cognition. During an interview on 8/27/24 at 3:37 p.m., Resident 57 stated, Resident 34 would wander into Resident 57's room and Resident 34 did not know what he was doing. Resident 57 stated, tolerating the wandering behavior due to Resident 34's Down's Syndrome, and was not high functioning. 2. A review of Resident 50's undated Admission Record, indicated, admission to the facility on [DATE], with the diagnoses of Alzheimer's disease (inability to remember), anxiety (feelings of fear and dread), depression, and obsessive-compulsive disorder (uncontrolled and recurring thoughts, repetitive behaviors, or both), and was a hospice resident (six months or less left to live and received care focused on comfort). Resident 50 was not his own RP. A review of Resident 50's MDS, dated [DATE], indicated, Resident 50 had severe cognitive impairment, wandered, and Resident 50's wandering did not intrude on the privacy or activities of others. A review of Resident 50's care plan titled, Elopement, dated 7/10/24, indicated, Resident 50's safety would not be in danger related to wandering behaviors. There was no intervention that indicated what staff should do when Resident 50 wandered into other resident rooms. During an interview on 8/27/24 at 11:27 a.m., Resident 267 stated, sometimes Resident 267 was bothered by Resident 50 wandering into Resident 267's room and that facility staff would have to remove Resident 50. During an interview on 8/28/24 at 8:04 a.m., Resident 48 stated, Resident 50 was his roommate, Resident 50 would wander into Resident 48's side of the room, and touch Resident 48's arm. Resident 48 stated, reporting Resident 50's behavior to staff in the past and nothing had been done about it. Resident 48 stated, if staff did not do something about it, Resident 48 would hurt Resident 50. During an interview on 8/28/24 at 2:46 p.m., Certified Nursing Assistant (CNA) G confirmed, Residents 34 and 50 wandered the facility and stated, they usually wander on the evening shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/24 at 2:50 p.m., CNA E confirmed, Resident 34 and Resident 50 wandered into other resident rooms. CNA E stated, there were issues between Resident 48 and his roommate (Resident 50) and in the past, Resident 48 had made verbal threats to hurt Resident 50. CNA E was asked about the care plan and interventions in place regarding Residents 34 and 50's wandering. CNA E stated unawareness of care plans or interventions. A record review of Resident 37 indicated she was admitted on [DATE] with diagnoses of a fracture at the right humerus, chronic kidney disease and secondary parkinsonism (a condition that causes symptoms like Parkinson's Disease (a disorder that affects the nervous system and parts of the body controlled by nerves) but is caused by an underlying medical condition or other factor). Resident 37's Brief Interview for Mental Status (BIMS, evaluation of mental function), dated 08/12/2024, score was 15, which indicated no mental impairment. Resident 37 is her own responsible party; she makes her own decisions. During an interview on 08/27/24 at 10:51 am, Resident 37 stated that two male residents come into the room uninvited. Resident 34 will not knock and enters the room on a daily basis. Resident 50 comes in twice a week. One of them even grabbed her leg. A record review of Resident 30 indicated she was admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD, a lung disease that blocks airflow and makes it difficult to breathe), diabetes (a disease that occurs when the body doesn't produce enough insulin (a hormone that regulates sugar in the blood) or can't use insulin properly), end stage renal disease, (a medical condition where the kidneys permanently stop working) and is dependent on dialysis (process of removing excess water, chemicals, and toxins from the blood by a machine), and has had both legs amputated (to cut off a limb by surgical operation) above the knee. Resident 30's Brief Interview for Mental Status (BIMS, evaluation of mental function), dated 08/05/2024, score was 10, which indicated a moderate mental impairment. Resident 30 is her own responsible party; she makes her own decisions. During an interview on 08/27/24 at 11:34 am, Resident 30 is, sick and tired of him (Resident 50) coming in here. Resident 50 has been in the room at least 5 times in the last few weeks and has been in the room twice today. He has drunk Resident 30's soda one week, another week while she was taking a nap, he got into her box of cereal and threw cereal at her while she was asleep, and recently drank her juice. Resident 34 also enters the room but he isn't a bother, he just roams. A review of Resident 43's medical record indicated that Resident 43 was admitted on [DATE] with diagnoses that included, Depression, muscle weakness, difficulty walking, and dementia. During an interview on 08/29/30, at 10:30 a.m., with Resident 43, Resident 43 stated, Resident 50 comes into my room and steals my cookies and drinks from my personnel water bottle and it is gross. During an interview with Activities Assistant 1 (AA 1) on 8/30/24 at 8:43 am, AA 1 stated Resident 50 mostly observed activities but did bother other residents by frequently tapping and touching others during activities. AA 1 stated Resident 50 had also spit chips in my face. During an interview on 8/28/24 at 2:57 p.m., CNA F confirmed, Resident 34 and Resident 50 wandered the facility. CNA F confirmed, Resident 34 wandered into other resident rooms and required redirection. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/27/24 at 3:04 p.m., Licensed Nurse (LN) A confirmed, Resident 34 wandered into other resident rooms. During a concurrent interview and record review on 8/29/24 at 10:20 a.m., with the Director or Nursing (DON), the care plans for Resident 34 were reviewed. DON confirmed, there was no care plan in place for Resident 34's wandering. DON stated, not being aware that Resident 34 wandered into other resident rooms. DON stated, not being aware that Resident 50 would wander into other resident rooms. DON reviewed Resident 50's care plan, titled Elopement, dated 7/10/24. DON confirmed, there were no interventions in place for Resident 50 regarding wandering into other resident rooms. DON stated, expectancy was for staff to notify DON of resident changes, DON would assess the resident, and revise the care plan to include appropriate interventions. 43031 3. During an observation on 8/27/24 at 12:30 pm, in the facility hallway outside and between rooms [ROOM NUMBERS], a plastic cup from room [ROOM NUMBER] flew into the hallway and broke when it hit the floor. Facility staff stated Resident 28 threw the cup. A review of Resident 16's medical record indicated that Resident 16 was admitted on [DATE] with diagnoses that included, Metabolic Encephalopathy (a brain dysfunction that occurs when the body's metabolism is affected and leads to chemical imbalances), COPD, and Respiratory Failure (not enough oxygen passes from the lungs to the blood). The Minimum Data Set (MDS, Tool for evaluating and implementing a standardized assessment) Brief Interview for Mental Status (BIMS, Section C assessing cognitive function) score dated 8/5/24 indicated Resident 16 rates 15/15, which equates to being cognitively intact. Resident 16 is their own representative (RP) and makes their own medical decisions. During an interview on 8/28/29 at 11:30 am, with Resident 16 in room [ROOM NUMBER] lying in bed A, Resident 16 stated, my neighbor in the other bed yells and throws things, cups, food items, whatever. I am afraid he will hit me with one of the plastic cups. I told him if he hits me with something I will come over there and blankity-blank. He said I'd like to see you do it. I can't get out of bed, however. Staff know what he does, and they shake it off. I don't feel safe with him. A review of Resident 28's medical record indicated that Resident 28 was admitted on [DATE] with diagnoses that included, Metabolic Encephalopathy, Squamous Cell Carcinoma of left ear (cancer), and COPD. The MDS BIMS score dated 5/24/24 indicated Resident 28 rates 7/15, which equates to severe cognitive impairment. Resident 28 is not their own RP and does not make their own medical decisions. During a review of Resident 28's Care plan, dated 5/21/24, the Care Plan indicated, Resident 28 was at risk for decreased psychosocial well-being, adjustment issues, emotional distress, ineffective coping skills, and poor impulse control .related to failure to thrive (a syndrome of global decline). There was no intervention that indicated what staff should do when Resident 28 demonstrated increased emotional distress, ineffective coping skills, and poor impulse control related to yelling, cursing, and throwing items. During an interview on 8/28/24 at 4:00 pm with Resident 28 in room [ROOM NUMBER] lying in bed B, Resident 28 acknowledges he yells and throws things and that he does not know why he yells and throws things. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/24 at 4:20 pm with Certified Nursing Assistant (CNA) H in the hallway outside of room [ROOM NUMBER], CNA H stated all of us (floor staff) are aware of Resident 16's behaviors. It happens often, something occurs daily depending on Resident 28's agitation. I Believe it may be related to upset about not seeing their spouse often. Resident 28 has not hit Resident 16 with anything that I am aware of. During an interview on 8/28/24 at 4:35 pm, with Licensed Vocational Nurse (LN) B at the medication cart in the hall by a resident's room. LN B acknowledges Resident 28's behaviors are known to the staff. He has increased agitation and throws things and yells. This is a regular occurrence. Resident 16 has not been hit with anything. During an interview on 8/29/24 at 08:30 am with Director of Nursing (DON) by the Nurse's Station, DON denies having previous knowledge of Resident 28's agitated behaviors, including yelling, cursing, and throwing items. I understand the staff was aware. We will educate staff on documentation and communication for increased agitated states and change of condition. We are getting a tele psyche consult.

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Yuba City Post Acute	1220 Plumas St Yuba City, CA 95991

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0697

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe, appropriate pain management for a resident who requires such services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43031

Based on observation, interview, and record review the facility failed to ensure that residents' pain was managed for 1 of 30 residents (Resident 216) sampled for pain management when Resident 216 complained of having pain in their ribs and low back while making facial expressions and exhibiting body movements that demonstrate signs related to the experience of pain. Resident 216 was unable to verbalize a specific number to represent the level of pain being experienced per the Pain Scale (standardized numeric scale to identify an individual's pain level. Scale rates pain from 0-10; 0 = no pain to 10 = most severe pain). Thus, Resident 216 did not receive pain medication per the medical doctor's (MD) orders.

This failure had the potential to result in an overall increase of pain, decline in mobility, increased health issue complications, and diminished mental, emotional, and psychosocial well-being.

Findings:

During a review of the facility's policy and procedure titled, Pain Assessment and Management, dated April 2024, the Pain Assessment and Management policy indicated, The purpose of this procedure are to help the staff identify pain in the resident .Observe the resident for signs and symptoms of pain .Possible Behavioral Signs of Pain: a. Verbal expressions of pain. b. Facial expressions such as grimacing, frowning .Assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level .Implement the medication regimen as per physician's orders . a physician, shall reconsider approaches and make adjustments if indicated to meet any further pain needs.

A review of Resident 216's medical record indicated that Resident 216 was admitted on [DATE] with diagnoses that included, fractured lumbar vertebrae and multiple fractured ribs, Chronic Obstructive Pulmonary Disease (COPD, inflammatory lung diseases that block airflow and make it difficult to breathe), and Dementia (loss of brain function such as memory, language, problem solving and other thinking abilities). The Minimum Data Set (MDS, Tool for evaluating and implementing a standardized assessment) Brief Interview for Mental Status (BIMS, Section C assessing cognitive function) score dated 8/28/24, indicated Resident 216 rates 3/15, which equates to severe cognitive impairment. Resident 216 is not their own representative (RP) and does not make their own medical decisions but can verbalize needs and preferences.

During a concurrent observation and interview on 8/28/24 at 09:00 am with Resident 216 in the hallway outside of the resident's room while in a wheelchair being pushed by Licensed Nurse (LN) C. Resident 216 was rocking backward and forward in the wheelchair holding their left side ribs, demonstrating facial grimacing, furrowed brow, and frowning while holding their forehead in their other hand. Resident 216 stated they were having quite a bit of pain in their ribs and back.

During an interview on 8/28/24 at 09:10 am with LN C in the hallway outside the Resident 216's room while LN C was pushing Resident 216 in a wheelchair, LN C acknowledged Resident 216 was having pain, that they had fallen at home and broken ribs and their low back which is why Resident 216 was admitted to the facility. LN C stated they would wait for the Medication Cart Nurse, LN D, to have a moment and get pain medication if available to give to Resident 216.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/28/24 at 09:15 am, at the end of the hallway by the medication cart, LN C and Resident 216 in a wheelchair were observed waiting to address LN D, the medication cart nurse. LN D and, LN C asked Resident 216 repeatedly to give a numeric pain scale number from 0-10 to represent their pain. Resident 216 was having difficulties identifying and verbalizing a numeric value, but 10 was heard at one point by surveyor. LN D determined the routine Tylenol had already been administered and the only other pain medication ordered per LN D's review of the Medication Administration Record (MAR, record where medication administration is documented) was Oxycodone (strong pain medication). LN C and LN D continued to request Resident 216 verbalize a pain scale number from 0-10. LN C and LN D spoke privately and then LN C wheeled Resident 216 away from the medication cart without having any pain medication oral (by mouth) or transdermal (applied to skin) administered. During a record review of Resident 216's Order Summary, dated August 2024, the Order Summary indicated that Acetaminophen (APAP, Tylenol) capsule 500 milligrams (mg, unit of measurement) was ordered to be given routinely as follows: Give 2 tablets by mouth every 8 hours for pain not to exceed (NTE) 3 grams (gm, unit of measurement) APAP in 24 hours from all sources. During a record review of Resident 216's MAR, the MAR indicated that Acetaminophen was administered to Resident 216 on 8/28/24 at the following times: 08:00 am was administered, 13:00 (1:00) pm was refused by resident, and 2100 (9:00) pm was administered. Start date 8/25/24. During a record review of Resident 216's Order Summary, dated August 2024, the Order Summary indicated that Oxycodone Hydrochloride (Oxycodone HCl, strong pain medication) 5 mg tablet was ordered to be given as follows: 1 tablet by mouth every 4 hours as needed for pain 6-10 for 3 days hold for respiratory rate (RR) less than (<)12. Start date 08/25/24. During a record review of Resident 216's MAR, dated August 2024, the MAR indicated Resident 216 received Oxycodone on 8/28/24 at 17:08 (5:08) pm for a pain level of 7. During a record review of Resident 216's Order Summary, dated August 2024, the Order Summary indicate that Lidocaine patches (pain medication infused in a patch form that is applied to the skin) 4 percent (%, quantitative measurement) were ordered to be applied as follows: apply to left (L) lateral side for rib pain in the morning, and Lidocaine patch 4% apply to low back in the morning for low back pain. Start date 8/26/24. During a review of Resident 216's MAR, dated August 2024, the MAR indicated Resident 216 refused the Lidocaine patches for 8/28/24. During an interview on 8/28/24 at 4:35 pm with LN B at the medication cart in the hall by a resident's room. LN B stated Resident 216 is a new admission, has pain but is confused, alert, but not oriented. Because of his dementia he refuses some of his pain medication. Resident 216 is not always able to verbalize pain per the numeric pain scale with a 0-10 response, but I would use the face and body assessment based on the grimacing, frowning, rocking, holding their side and guarding while holding their forehead, along with the mumbling, moaning, or making statements about having quite a bit of pain to determine the pain level. I would think it would be a higher level of pain if most of these actions were observed, probably at least a 6 or 7. It is a pain assessment for advanced dementia (PainAD, Assessment tool that monitors dementia/nonverbal residents for labored breathing, moaning/groaning, facial expressions, tense body language, and consolability to determine resident pain) that I would use. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/29/24 at 11:30 am with DON in the conference room. DON confirmed the painAD should have been utilized if the resident could not verbalize a numeric figure to represent their pain. The assessment looks at facial expressions, grimacing, frowning, moaning, and behaviors such as rocking, clenching fists, holding, or guarding an area. DON concurs staff will receive more training on identifying or recognizing pain and managing it adequately especially for dementia residents. 49418 A review of Nursing Note written by LN C, dated 8/28/24 at 9:04 am, indicated Resident 216 had his toes run over by a wheelchair this morning, but resident did not appear in pain. During observation of medication administration on 8/28/24 at 9:15 am, LN C stated Resident 216 bumped his foot and asked LN D if Resident 216 could have Tylenol. Resident 216 was wearing socks on his feet, seated in a wheelchair and observed to rock back and forth, head in his hands, rubbing his left side, and making facial grimaces. LN C asked Resident 216 multiple times to rate his pain on a scale of 1 to 10; the pain scale was not explained to the resident, who appeared to be confused by the question. Resident 216 stated, I don't know, 10. LN D reviewed Resident 216's medication list and stated Resident 216 had received a dose of scheduled Tylenol that morning, and the only other medication available was oxycodone (an opioid pain-relief medication for moderate to severe pain). LN D again asked Resident 216 to rate his pain on a scale of 1 to 10, and Resident 216 replied, I don't have any. No medication was given, and Resident 216 was taken away by LN C. During an interview with LN C on 8/28/24 at 10:51 am, LN C stated she brought Resident 216 to LN D because he hit his toe on his wheelchair and was in pain. LN C stated he also fell recently and had pain from fractured ribs. LN C acknowledged Resident 216 did not receive any pain medication and stated he wasn't showing pain. A review of Resident 216's Medication Administration Record (MAR), dated 8/1 to 8/31/24, printed 8/29/24 at 12:52 pm, indicated Resident 216 refused all ordered lidocaine patches to left side and low back since admission; received Tylenol 10 times since admission but refused scheduled doses at 1 pm on 8/25 and 8/28/24; denied having pain 10 times since admission, with one report of 1 out of 10 pain on morning shift 8/28/24; nonpharmacological pain interventions of repositioning/limb elevation seven times and rest period/quiet environment 11 times since admission; and oxycodone 5 mg was given three times for severe pain 7 out of 10 on 8/26/24 at 7:24 am, 8/26/24 at 9:55 pm, and 8/28/24 at 5:08 pm. During concurrent interview with LN D and review of Resident 216's active orders on 8/28/24 at 2:52 pm, LN D stated Resident 216 had complained of left rib pain but had refused pain medications. LN D stated he did not give Resident 216 oxycodone for pain at 9 am because the resident couldn't give him a pain scale and LN D didn't think [Resident 216] was in pain. LN D acknowledged that the lidocaine patches scheduled at 9 a. m. were not offered because Resident 216 refuses those. LN D acknowledged Resident 216 had received only one dose of Tylenol for pain relief. During an interview with LN C and LN D on 8/28/24 at 3:08 pm, LN C stated the protocol when residents refuse ordered medications is to ask the resident three times to take the medication, explain the risks and benefits, and if the resident still refuses, the doctor will be informed. LN C and LN D acknowledged they had not notified anyone that Resident 216 had frequently refused pain medications since admission. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of P&P titled Change in a Resident's Condition or Status, dated 4/2024, indicated the nurse will notify the resident's physician/nurse practitioner/physician assistant when there has been a(an) refusal of treatment or medications. During concurrent observation and interviews with Resident 216 and Activities Assistant 1 (AA 1) on 8/28/24 at 3:17 pm in the dining area, observed Resident 216 sitting in a wheelchair near other residents during Activities (Bingo). Resident 216 was not participating but was observed fidgeting with the drawstring of his sweatpants, a plastic bracelet on his wrist, and lifting his T-shirt to intermittently rub his left side. When questioned about pain, Resident 216 stated his side hurt and pointed to his left ribs. Informed Resident 216 he had pain patches that could be applied by nursing staff. Resident 216 stated he needed to remove the patch from his wrist and took off his bracelet. AA 1 stated she believed Resident 216 was in pain because he had been verbalizing ow and grimacing throughout the activity. During an interview with the DON on 8/29/24 at 11:38 am, discussed the observation of Resident 216, LN C, and LN D on 8/28/24 at 9:15 am, with the result being no pain medication given. The DON stated, That's so frustrating. The DON stated she would provide education to nursing staff regarding the Pain Assessment in Advanced Dementia Scale (PAINAD - an assessment tool that monitors dementia/nonverbal residents for labored breathing, moaning/groaning, facial expressions, tense body language, and consolability). During an interview with DON, Administrator (ADM), and Administrator in Training (AIT) on 8/29/24 at 4:34 pm, the DON stated the MD was here 8/28/24 and was made aware that not all pain medications were being administered to Resident 216 despite indications of pain. The DON again stated she was frustrated that nursing staff did not recognize Resident 216's nonverbal indications of pain and would re-educate staff to the PAINAD scale.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43031 Based on observation, interview and record review the facility failed to assure that there was sufficient, qualified nursing staff available at all times to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being for 11 of 30 residents (Resident 215, 28, 57, 45, 5, and 365), and Confidential Interview Residents), when call lights were observed and reported to go unanswered for extended periods of time resulting in: 1. Residents being left in soiled briefs with bowel movement and/ or urine. 2. Residents being left on the toilet for extended periods of time. 3. Residents left waiting for assistance in bed for a variety of reasons, including for generalized needs, or attempting to receive assistance to go to the to toilet. 4. Residents experiencing health concerns such as pain and shortness of breath (SOB). This failure had the potential to result in skin breakdown, increased overall pain, increase of resident accidents, and falls due to frustration and attempted self-help, decline in physical health status, and diminished mental and psychosocial well-being. Findings: During a review of the facility's policy and procedure (P&P) titled Answering the Call Light, dated October 2023, Answering the Call Light indicated the purpose of the procedure is to respond to residents' requests and needs .Answer the residents' call light as soon as possible. During a review of the facility's Job Description for Certified Nursing Assistant (CNA), dated 2-2019, CNA Job Description indicated, The primary purpose of your job position is to provide each of your assigned residents routine daily nursing care and services .Ensure residents who are unable to call for help are checked frequently .answer residents call promptly. During a review of the facility's Job Description for Licensed Vocational Nurse (LVN), dated 11-2018, LVN Job Description indicated, The primary purpose of your job position is to provide direct nursing care to the residents, and supervise the day-to-day nursing activities performed by nursing assistants .Direct the day-to-day function of the nursing assistants in accordance to rules, regulations .Ensure all nursing service personnel are in compliance with the respective job description .Ensure that personnel providing direct care to residents are providing such care (continued on next page)

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

A review of Resident 28's medical record indicated that Resident 28 was admitted on [DATE] with diagnoses that included, Metabolic Encephalopathy, Squamous Cell Carcinoma of left ear (cancer), and COPD. The Minimum Data Set (MDS, Tool for evaluating and implementing a standardized assessment) Brief Interview for Mental Status (BIMS, Section C assessing cognitive function) score dated 5/24/24, indicated Resident 16 rates 7/15, which equates to severe cognitive impairment. Resident 28 is not their own RP and does not make their own medical decisions but can verbalize preferences and needs.

During an interview on 8/28/24 at 4:00 pm with Resident 28 while lying in their bed in their room, Resident 28 stated, Staff sometimes answer my call light. It takes a long time a lot, 30 minutes, even when I am on the toilet.

A review of Resident 215's medical record indicated that Resident 215 was admitted on [DATE] with diagnoses that included, displaced fracture of shaft of left clavicle, Chronic Obstructive Pulmonary Disease (COPD, inflammatory lung diseases that block airflow and make it difficult to breathe), and Cerebrovascular event history (stroke, blood flow to the brain is lost damaging brain tissue). The MDS BIMS score dated 8/18/24, indicated Resident 215 rates 15/15, which equates to being cognitively intact. Resident 215 is their own representative (RP) and makes their own medical decisions.

During an interview on 8/27/24 at with Resident 215 while sitting in their bed in their room, Resident 215 stated Staff are not consistent with answering the call lights. The call lights are not answered timely. I have watched the clock and waited for 30 minutes for my light to be answered, that is regularly. My son came in one day and my call light was on because I needed assistance, no one came in to answer it. We waited for a while, then he had to finally go to the nurse's station to see if they were going to help me. I had my light on before he even got here. I don't know how long that was, but it was a long time.

During a confidential interview on 8/29/24 at 1:30 pm with Resident Council members, four of nine sampled residents stated that it takes a while for staff to answer the call lights especially when the Certified Nursing Assistant (CNA) assigned is on break or is busy. No one else will answer those lights. Sometimes on the night shift the entire staff goes on break together leaving only the medication cart nurse available for all issues including answering call lights. It takes a while to answer call lights then. We have seen it. We have been looking for staff for assistance and gone into the break room and found all the staff taking their dinner break together. Two of nine residents state they have to use the call light for their roommate because the roommate either cannot locate their call light, or staff is not answering the call light timely because the roommate calls too much.

45315

A review of the undated Admission Record, indicated, Resident 45 was admitted to the facility on [DATE] with the diagnoses of acute (happened quickly) respiratory failure (a serious condition that made it hard to breathe) unspecified whether with hypoxia (low oxygen levels that can cause confusion, rapid heart rate, and difficulty breathing) or hypercapnia (to much carbon dioxide in the body that could cause shortness of breath, tiredness, or confusion), difficulty in walking, and hypertension.

A review of Resident 45's MDS, dated [DATE], indicated, Resident 45 had good cognition.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/27/24 at 3:47 p.m., Resident 45 stated, pressing the call light during the afternoon and waited for two hours before facility staff responded. Resident 45 stated, a few times she had urinated on herself while waiting for facility staff to respond to the call light and it happened mostly in the afternoon. A review of the undated Admission Record, indicated, Resident 5 was admitted to the facility on [DATE], with the diagnoses of chronic (ongoing) acute respiratory failure unspecified whether with hypoxia or hypercapnia, difficulty in walking, and chronic pain syndrome. Resident 5 was not her own RP. A review of Resident 5's MDS, dated [DATE], indicated, Resident 5 had good cognition. During an interview on 8/28/24 at 7:41 a.m., Resident 5 made statements of feeling ignored due to staff not answering the call light in a timely manner and stated it was difficult to find staff to assist when help was needed. A review of the undated Admission Record, indicated, Resident 57 was admitted to the facility on [DATE] with the diagnoses of fracture of shaft of left tibia (a fracture of the larger leg bone that occurred below the knee joint), pain, and had a history of falling. Resident 45 was her own RP and made her own decisions. A review of Resident 57's MDS, dated [DATE], indicated, Resident 57 had good cognition (ability to remember). During an interview on 08/27/24 at 3:37 p.m., Resident 57 stated, having pain and utilized the call light to request pain medication. Resident 57 stated, it took staff 45 minutes to respond to the call light. 49934 A record review of Resident 365 indicated he was admitted on [DATE] with diagnoses of surgical aftercare following surgical amputation (to cut off a limb by surgical operation), cellulitis (bacterial skin infection) of the right lower limb, diabetes (a disease that occurs when the body doesn't produce enough insulin (a hormone that regulates sugar in the blood) or can't use insulin properly), end stage renal disease, (a medical condition where the kidneys permanently stop working) and is dependent on dialysis (process of removing excess water, chemicals, and toxins from the blood by a machine). Resident 365's Brief Interview for Mental Status (BIMS, evaluation of mental function), dated 08/20/2024, score was 15, which indicated no mental impairment. Resident 365 is his own responsible party; he makes his own decisions. During an interview on 08/27/24 at 3:52 pm, Resident 365 stated he waited for 40 minutes to have his call light answered. He stated he was having breathing issues, and it took them 40 minutes! His roommate yelled and used his whistle to get someone to answer the call light. His oxygen flow was increased and Resident 365 states he is happy with his oxygen setting. Physician orders, dated 08/14/2024, note that the oxygen may be titrated as indicated, during an activity or therapy, and if greater than 5 liters is needed, notification of the doctor is required.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49418 Based on observation, interview, and record review, the facility failed to ensure complete Medication Regimen Reviews (MRR) were performed for medication irregularities, appropriate indication (reason for use), and/or unnecessary psychotropic (affecting mental state) medications for two of four sampled residents (Residents 50 and 25) when: 1A. The indication for Seroquel (medication affecting mental processing and behaviors) use of mood disorder as evidenced by (AEB) striking during care was determined appropriate for Resident 50 on two MRRs by Consultant Pharmacist (CPH), though medication necessity and effectiveness had not been evaluated (50 days after admission) by the Psychotropic Interdisciplinary Team (IDT - group of professional healthcare providers including physician(s), nurses, pharmacists who meet to determine appropriateness of resident medication treatment plans). 1B. No medication irregularities were reported by CPH for Resident 50 despite Seroquel being administered in combination with donepezil (dementia medication that slows mental changes and improves behaviors), which is known to potentially reduce the effectiveness of donepezil and cause nervous system side effects of increased drowsiness, confusion, and mental impairment in dementia residents. These failures had the potential for Resident 50 to receive an unnecessary psychotropic medication without improvement goals and to suffer unnecessary adverse (harmful) effects that could negatively impact his physical, mental, and psychosocial well-being. 2. Resident 25 received oxybutynin (treats bladder control problems) 5 milligrams (mg - a unit of measure) extended-release (ER) tablets from 6/1/24 to 8/29/24 rather than the immediate-release (IR) formula that was ordered by the Medical Director (MD) - an error that went undetected and unreported for irregularity by CPH. This failure caused Resident 25 to receive a longer-lasting dose of oxybutynin with the potential to cause adverse effects from excessive build-up of the medication in his system that could negatively impact his physical, mental, and psychosocial well-being. FINDINGS: During a review of facility Policy and Procedure (P&P) titled Medication Regimen Review, dated 4/2024, the P&P indicated: A. When needed, a licensed nurse, Pharmacist, and/or Practitioner will review a resident's current medication regimen to identify whether (1) there is a clear indication for treating the resident with the medication, (2) the dosage is as prescribed by the physician, (3) the frequency of administration and duration of use are appropriate. B. Monthly, the Pharmacist and/or Physician will review the medication regimen for continued indications, dose and duration that is consistent with the order, and possible side effects. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. The Pharmacist and/or Physician will coordinate with the Director of Nursing (DON) or designee where medications should be tapered, discontinued, or changed to another medication. A review of P&P titled Antipsychotic Medication Use, dated 2023, indicated: A. The physician will identify, evaluate, and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. B. Residents admitted from the community who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use. Based on assessing the resident's symptoms and overall situation, the physician will determine whether to continue, adjust, or stop existing antipsychotic medication. C. Antipsychotic medications will be used only for the following conditions/diagnoses as documented in the record: schizophrenia, delusional disorder, mood disorders (bipolar disease, depression with psychotic features, and major depression not responding to treatment), psychosis in the absence of dementia, and behavioral and psychological symptoms of dementia (BPSD). A review of P&P titled Dementia Care, dated 11/2023, indicated: A. The staff and physician will evaluate individuals with new or worsening cognitive (mental function) impairment and behavior and differentiate dementia from other causes. B. The physician will help define potential benefits and risks of medical interventions based on individual risk factors, current conditions, history, and details of current symptoms. C. The Interdisciplinary Team (IDT - a team with members from different disciplines who work together to set goals and make care decisions) will identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise. A review of record titled Medical Directorship Agreement signed by MD, dated 2/1/23, indicated MD duties included participating in effective resident care utilization review (UR - process to evaluate appropriateness and necessity of healthcare services) and participating in the development of medical care plans for each resident to include medications, nursing care, restorative services (interventions that help residents regain or maintain their ability to live independently and safely), diet, and other services. A review of record titled Physician Job Description signed by MD, dated 6/7/23, indicated primary accountabilities include prescribing medications, detecting, and responding to adverse drug reactions, and collaborating with healthcare professional staff to form a high-performing medical team. 1A. A review of Resident 50's medical records indicated he was admitted to the facility in early July 2024 with diagnoses of Alzheimer's dementia (causes progressive memory loss, inability to control thoughts and language), anxiety, depression, and obsessive-compulsive disorder (OCD - uncontrolled recurring thoughts, repetitive behaviors, or both), and was on hospice (had six or fewer months to live, receiving care focused on comfort). Family Member 1 (FM 1) was his Responsible Party (RP) because Resident 50 was not able to make his own healthcare decisions. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of outside records titled Office/Clinic Notes, dated 3/11/24, indicated Resident 50 was taking quetiapine (Seroquel - a psychotropic medication; affects mental processes and behaviors) 25 mg, one tablet twice a day for sleep and disinhibition (inability to control behaviors). The record indicated recommendation to continue Seroquel 25 mg twice a day, titrate (adjust) as needed/tolerated. Adverse effects of Seroquel include sedation, orthostatic hypotension (drop in blood pressure within three minutes of standing), lightheadedness, dry mouth, blurred vision, constipation, urinary retention, increase psychotic symptoms, extrapyramidal effects (continuous spasms and muscle contractions), restlessness, dystonia (involuntary muscle contractions that cause repetitive or twisting movements), tremor, rigidity, akinesia (loss or impairment of the power of voluntary movement), tardive dyskinesia, (irregular, jerky movements). A review of outside records titled Hospice Nursing Clinical Note, dated 7/3/24, indicated Resident 50's Seroquel was increased to 100 mg in the morning, to continue 50 mg at bedtime, due to aggression. A review of outside records titled Hospice Nursing Clinical Note, dated 7/9/24, indicated the increased Seroquel had helped Resident 50's outbursts, but he was using his walker more often due to weakness, had become more clumsy, and almost fell on [DATE]. A review of letter from California Department of Health Care Services (DHCS) to facility on 7/10/24, indicated DHCS was unable to complete evaluation for serious mental illness for Resident 50. The letter indicated a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation was not completed because facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I Screening. The letter indicated the case was closed but could be reopened by submitting a new Level I Screening. A review of Care Plan, dated 7/10/24, indicated: A. Resident 50 was at risk for falls with or without injury related to altered mental status, antidepressant medication, antipsychotic medication, antihypertensive medication, with order to perform MRR as indicated. B. The record indicated Seroquel carried a black box warning (label used by the United States Food and Drug Administration to alert prescribers and patients to most serious safety risks) with potential adverse effects of sedation, falls, abnormal movements, negative cardiovascular (heart/vessels) effects, stroke, and increased mortality in older adult patients. Interventions dated 7/15/24: Attempt a gradual dose reduction as indicated/condition improves, as ordered; pharmacy review as indicated; attempt non-pharmacological approaches prior to medication administration; and observe/record effectiveness of drug treatment as indicated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yuba City Post Acute	1220 Plumas St Yuba City, CA 95991

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Minimum Data Set (MDS - a tool used to assess and manage care of residents in nursing homes) Brief Interview for Mental Status (BIMS - screens a resident's mental status using score 0 to 15: 0-7 severe impairment, 8-12 moderate impairment, 13-15 intact mental function), dated 7/16/24, indicated Resident 50 had a BIMS Score of 5, indicating severe impairment of mental function. The record indicated Resident 50 displayed no hallucinations or delusions (potential indicators of psychosis) and no physical (hitting, kicking, pushing), verbal (threatening others, screaming, cursing), or other behavioral symptoms (pacing, throwing food or bodily wastes, disrobing in public). The record indicated Resident 50 had wandering behavior one to three days. A review of Order Summary Report, dated 8/29/24, indicated orders as follows: A. A medication reconciliation (comparing resident's medication orders to current medications to ensure accuracy and avoid errors) was performed by MD with review of the prior care setting discharge medications on 7/10/24. B. Seroquel 100 mg, one tablet once a day (morning), Seroquel 50 mg, one tablet once a day (evening) for mood disorder as evidenced by striking during care, with start dates of 7/11/24 and 7/10/24, respectively. C. Every shift for Seroquel, observe resident closely for significant common side effects of drowsiness/sedation, dry mouth, constipation, blurred vision, urinary retention (unable to urinate), loss of appetite, with special attention for tardive dyskinesia (involuntary movements), seizure disorder, chronic constipation, diabetes. Start date 7/13/24. D. Admit to Hospice for diagnosis of senile degeneration of the brain. Start date 7/19/24. During an interview with DON on 8/29/24 at 11:38 am, the DON stated Resident 50's Seroquel was ordered because he was striking out during any Activities of Daily Living (ADLs - feeding, toileting, dressing) care. DON stated Resident 50 can get aggressive sometimes during care, and this prevented him from getting care. During an interview with Medical Director (MD) on 8/29/24 at 3:05 pm, MD stated she followed hospice admission orders when ordering Resident 50's medications for facility admission in July. MD stated the hospice record showed the indication for Seroquel was striking out, agitation. MD stated, My name will be on every order, even if following hospice orders. MD stated persons responsible for reviewing medications at admission include the physician (herself), the DON, MDS Nurse, and the Pharmacist. MD stated she takes part in monthly resident medications reviews at the facility but was on vacation in August and did not participate that month. MD stated Resident 50's medications had not yet been reviewed by the Psychotropic IDT. During an interview with Registered Nurse B (RN B) on 8/29/24 at 3:12 pm, RN B stated Resident 50 was living at home prior to admission to the facility, but Family Member 1 (FM 1) can't handle his increasingly aggressive behaviors of hitting, spitting, smearing, and eating his own feces, so he was admitted to the facility on hospice. RN B stated she evaluated Resident 50 twice weekly at the facility and he was more calm. RN B stated he used to hit and spit, but staff said he was not doing that as much. RN B stated family is happy that his behaviors are improving. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER: Yuba City Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 1220 Plumas St Yuba City, CA 95991	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation of Resident 50 in his room on 8/30/24 at 8:31 am, Resident 50 was lying on his right side, resting quietly, eyes closed, the overhead lights out but curtains open to provide a dimly lit room. During an interview with LN A on 08/30/24 at 08:40, LN A stated Resident 50 was usually calm but had one episode of wandering yesterday. LN A stated she did not believe Resident 50 was a danger to himself or others. A review of records titled Consultant Pharmacist's Medication Regimen Review: List of Patients Reviewed/Recommendations from July and August 2024 indicated Resident 50's medication regimen was reviewed with no recommendations for change or gradual dose reduction (GDR). A review of drug information for Seroquel on [NAME]-Drug (a drug reference platform that provides clinicians information to help make evidence-based drug decisions), updated 9/4/24, indicated elderly patients with dementia-related psychosis (mental condition that causes a person to lose touch with reality) who are treated with antipsychotic drugs are at an increased risk of death. Seroquel is not approved for the treatment of patients with dementia-related psychosis and is to be avoided for behavioral problems associated with dementia or delirium unless alternative nonpharmacologic therapies have failed and patient may harm self or others. If Seroquel is used, clinicians should consider deprescribing attempts to assess continued need and/or lowest effective dose. 1B. A review of Resident 50's Order Summary Report, dated 8/29/24, indicated an order for donepezil hydrochloride (dementia medication that slows mental changes and improves behaviors) 10 milligrams (mg - a unit of measure), one tablet once a day, start date 7/11/24. During an interview with Consultant Pharmacist (CPH) on 8/29/24 at 3:45 pm, CPH stated he checked medications and reviewed order input for appropriateness and accuracy of orders when residents were admitted , checked that allergies were entered correctly, that psychotropic medications had behavior and side effect monitoring ordered, and that no drug-drug interactions (reaction between drugs, often negative) were likely to occur. CPH stated the contraindications (reasons against doing something) of Seroquel use in elderly residents with dementia, particularly when used in combination with donepezil, were not clear and that there was positive data supporting the use of antipsychotics for dementia symptoms. CPH stated, A lot of doctors use it for these symptoms. CPH stated Resident 50's Hospice Admission Orders looked familiar and were probably what he used to verify medication orders. CPH verified that as of this interview, Resident 50's medications had not yet been reviewed by the Psychotropic IDT, 50 days after admission. A review of drug information for donepezil on [NAME]-Drug, updated 9/7/24, indicated donepezil may enhance the neurotoxic (damage to brain or nervous system caused by exposure to toxic substances) effects when used in combination with antipsychotic agents like Seroquel. 2. During a review of Resident 25's medical records, the record indicated Resident 25 was admitted in 10/2023 with diagnoses including unspecified symptoms of the genitourinary system (organs of the urinary and reproductive systems) and enlarged prostate. A review of facility document prepared by CPH titled Consultant Pharmacist's Medication Regimen Review: Listing of Residents Reviewed with No Recommendations, dated 7/2024, indicated Resident 25's medication regimen was reviewed and did not require any recommendations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055092	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yuba City Post Acute	1220 Plumas St Yuba City, CA 95991

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation of medication administration on 8/28/24 at 8:42 am, Licensed Nurse D (LN D) prepared and administered Resident 25's medications, which included removing one tablet from a blister pack (medication packaging, packaged by the pharmacy) labeled oxybutynin extended-release (ER) 5 mg tab - take 1 tablet three times daily for overactive bladder. A review of Resident 25's Order Summary Report, dated 8/29/24, indicated an active order for oxybutynin chloride oral tablet 5 mg, to give one tablet by mouth three times a day for overactive bladder. The order was placed 6/1/24 with start date of 6/1/24. During concurrent observation of Resident 25's oxybutynin blister pack, review of Resident 25's active medication orders, and interview with LN D on 8/28/24 at 2:52 p.m., LN D acknowledged that the oxybutynin order did not indicate to use the ER formula of oxybutynin. During an interview with the Registered Pharmacist (RPH) on 8/28/24 at 12:36 p.m., RPH reviewed Resident 25's oxybutynin order. RPH stated the medication was first ordered 6/1/24 and had been filled three times. RPH verified the order indicated oxybutynin IR formula was to be given three times a day, not the ER formula. RPH stated, This is a medication error. RPH stated oxybutynin 5 mg ER should only be given once daily, not three times a day, noting it was done incorrectly. Review of Resident 25's Medication Administration Record, dated 8/1 to 8/31/24, indicated oxybutynin ER 5 mg was administered 83 times in 8/2024. During an interview with the Medical Director (MD) on 8/29/24 at 3:05 p.m., the MD stated, We all play a role in preventing medication errors and discrepancies: Pharmacy staff, MD and DON who review resident medications, MDS Nurse, and nursing staff who administer medications. During an interview with the Consulting Pharmacist (CPH) on 8/29/24 at 3:45 p.m., the CPH verified the pharmacy sent the longer acting ER formula in error. CPH stated it was interesting that oxybutynin got sent as ER. CPH stated in this case, the medication error should have been noticed by in-house pharmacists who reviewed the orders. CPH stated, If I were the pharmacist, I'd have questioned it. CPH stated the ER formula would take longer to metabolize (break down) and would stay in Resident 25's system longer than the IR formula. CPH stated he agreed with the MD's order to switch to oxybutynin IR and monitor Resident 25 for potential adverse effects of receiving the longer-acting ER formula three times a day for three months (6/1 to 8/29/24).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49418 Based on observation, interview, and record review, the facility failed to review indications for continued use or attempt Gradual Dose Reduction (GDR - tapering of a dose to determine if symptoms, conditions, or risks can be managed by lowering or discontinuing medication) for 50 days for one of one sampled resident (Resident 50) receiving four psychotropic medications: (1) lorazepam (anti-anxiety medication that slows brain activity for relaxation), (2) Seroquel (anti-psychotic medication, indicated for psychosis, that improves mood, thoughts, and behaviors), (3) trazodone (anti-depressant medication), and (4) sertraline (anti-depressant - increases serotonin, a mood-enhancing chemical, in the brain). Psychotropic medications affect brain activities associated with mental processes and behaviors and include anti-psychotic, anti-depressant, and anti-anxiety medications. This deficient practice had the potential for Resident 50 to experience adverse (negative, potentially harmful) side effects including sedation, falls, abnormal involuntary movements, stroke, and death from inappropriate indication for use and/or excessive or unnecessary psychotropic medications. FINDINGS: A review of record titled Medical Directorship Agreement signed by Medical Director (MD), dated 2/1/23, indicated MD duties included participating in effective resident care utilization review (UR - process to evaluate appropriateness and necessity of healthcare services) and participating in the development of medical care plans for each resident, to include medications. A review of record titled Physician Job Description signed by MD, dated 6/7/23, indicated primary accountabilities included prescribing medications, detecting, and responding to adverse drug reactions, and collaborating with healthcare professional staff to form a high-performing medical team. During a review of facility Policy and Procedure (P&P) titled Medication Regimen Review, dated 4/2024, the P&P indicated: A. When needed, a licensed nurse, Pharmacist, and/or Practitioner will review a resident's current medication regimen to identify whether (1) there is a clear indication for treating the resident with the medication, (2) the dosage is as prescribed by the physician, (3) the frequency of administration and duration of use are appropriate. B. Monthly, the Pharmacist and/or Physician will review the medication regimen for continued indications, dose and duration that is consistent with the order, and possible side effects. C. The Pharmacist and/or Physician will coordinate with the Director of Nursing (DON) or designee where medications should be tapered, discontinued, or changed to another medication. A review of P&P titled Antipsychotic Medication Use, dated 2023, indicated: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. The physician will identify, evaluate, and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. B. Residents admitted from the community who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use. Based on assessing the resident's symptoms and overall situation, the physician will determine whether to continue, adjust, or stop existing antipsychotic medication. C. Antipsychotic medications will be used only for the following conditions/diagnoses as documented in the record: schizophrenia, delusional disorder, mood disorders (bipolar disease, depression with psychotic features, and major depression not responding to treatment), psychosis in the absence of dementia, and behavioral and psychological symptoms of dementia (BPSD). A review of P&P titled Dementia Care, dated 11/2023, indicated: A. The staff and physician will evaluate individuals with new or worsening cognitive (mental function) impairment and behavior and differentiate dementia from other causes. B. The physician will help define potential benefits and risks of medical interventions based on individual risk factors, current conditions, history, and details of current symptoms. C. The Interdisciplinary Team (IDT - a team with members from different disciplines who work together to set goals and make care decisions) will identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise. A review of Resident 50's medical records indicated he was admitted in early July 2024 with diagnoses of Alzheimer's dementia (progressive memory loss, inability to control thoughts and language), dementia with mood disturbance, chronic pain, neuropathy (nerve pain), history of falls, anxiety, depression, insomnia, skin-picking disorder, and obsessive-compulsive disorder (OCD - uncontrolled recurring thoughts, repetitive behaviors, or both). The record indicated Resident 50 was placed on hospice (having six or fewer months to live, receiving care focused on comfort) in July 2024. Resident 50 was unable to make his own healthcare decisions, and Family Member 1 (FM 1) was his Responsible Party (RP). A review of Minimum Data Set (MDS - a tool used to assess and manage care of residents in nursing homes) showed Brief Interview for Mental Status (BIMS - tool to screen a resident's mental status using score 0 to 15: 0-7 severe impairment, 8-12 moderate impairment, 13-15 intact mental function), dated 7/16/24, which indicated Resident 50's BIMS Score was 5, indicating severe mental function impairment. The record indicated Resident 50 displayed no hallucinations or delusions (potential indicators of psychosis) and no physical (hitting, kicking, pushing), verbal (threatening others, screaming, cursing), or other behavioral symptoms (pacing, throwing food or bodily wastes, disrobing in public). The record indicated Resident 50 had wandering behavior one to three days. A review of Order Summary Report, dated 8/29/24, indicated orders as follows: 1. A medication reconciliation (comparing resident's medication orders to current medications to ensure accuracy and avoid errors) was ordered and performed by MD with review of the prior care setting discharge medications on 7/10/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Lorazepam (generic for Ativan) 0.5 milligrams (mg - a unit of measure), one tablet every two hours as needed for 14 days for anxiety as evidenced by (AEB) restlessness. Start date 8/27/24, end date 9/10/24. 3. Anti-anxiety Medication Use (Ativan): Observe resident closely every shift for significant side effects of sedation, ataxia (drunk walk), dizziness, nausea, vomiting, confusion, headache, blurred vision, skin rash. Special attention if given with other sedatives, hypnotics, or alcohol. Start date 7/13/24. 4. Seroquel 100 mg, one tablet once a day (morning), Seroquel 50 mg, one tablet once a day (evening) for mood disorder AEB striking during care, with start dates 7/11/24 and 7/10/24, respectively. 5. Anti-Psychotic Medication Use (Seroquel): Observe resident closely every shift for significant side effects of drowsiness/sedation, dry mouth, constipation, blurred vision, urinary retention (unable to urinate), loss of appetite. Special attention for tardive dyskinesia (involuntary movements), seizures, chronic constipation, diabetes. Start date 7/13/24. 6. Trazodone hydrochloride 100 mg, two tablets once a day for insomnia AEB inability to get good night's sleep. Start date 7/10/24. 7. Sertraline hydrochloride 100 mg, two tablets once a day for OCD AEB body-focused repetitive behavior. Start date 7/11/24. 8. Anti-Depressant Medication Use (trazodone, sertraline): Observe resident closely every shift for significant side effects of sedation, drowsiness, dry mouth, blurred vision, urinary retention (unable to urinate), fast heart rate, muscle tremor, agitation, headache, skin rash, excess weight gain. Special attention for heart disease, chronic constipation, seizures, and edema (fluid trapped in body tissues). Start dates 7/14/24 (trazodone), 7/13/24 (sertraline). 9. Donepezil hydrochloride (dementia medication that slows mental changes and improves behaviors) 10 mg, one tablet once a day. Start date 7/11/24. A review of Care Plan, dated 7/10/24, indicated: 1. Resident 50 was at risk for falls with or without injury related to altered mental status, antidepressant medication, antipsychotic medication, antihypertensive medication, with order to perform MRR as indicated. 2. Seroquel carried a black box warning (label used by the United States Food and Drug Administration to alert prescribers and patients to most serious safety risks) with potential adverse effects of sedation, falls, abnormal movements, negative cardiovascular (heart/vessels) effects, stroke, and increased mortality in older adult patients. 3. Seroquel interventions, dated 7/15/24, included to attempt a gradual dose reduction as indicated/condition improves, as ordered; pharmacy review as indicated; attempt non-pharmacological approaches prior to medication administration; and observe/record effectiveness of drug treatment as indicated. (continued on next page)

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F 0758

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

A review of drug information for Seroquel on [NAME]-Drug (a drug reference platform that provides clinicians information to help make evidence-based drug decisions), updated 9/4/24, indicated elderly patients with dementia-related psychosis (mental condition that causes a person to lose touch with reality) who are treated with antipsychotic drugs are at an increased risk of death. Seroquel is not approved for the treatment of patients with dementia-related psychosis and is to be avoided for behavioral problems associated with dementia or delirium unless alternative nonpharmacologic therapies have failed and patient may harm self or others. If Seroquel is used, clinicians should consider deprescribing attempts to assess continued need and/or lowest effective dose.

A review of drug information for donepezil on [NAME]-Drug, updated 9/7/24, indicated donepezil may enhance neurotoxic (damage to brain or nervous system caused by exposure to toxic substances) effects when used in combination with antipsychotic agents like Seroquel.

A review of records titled Consultant Pharmacist's Medication Regimen Review: List of Patients Reviewed/Recommendations from July and August 2024 indicated Resident 50's medication regimen was reviewed by Consultant Pharmacist (CPH) with no recommendations for change.

During an interview with the Director of Nursing (DON) on 8/29/24 at 11:38 am, DON stated Resident 50's Seroquel was ordered because he was striking out during any Activities of Daily Living (ADLs - feeding, toileting, dressing) care. DON stated Resident 50 can get aggressive sometimes during care, and this prevented him from getting care.

During an interview with Medical Director (MD) on 8/29/24 at 3:05 pm, MD stated persons responsible for reviewing medications at admission include the physician (herself), the DON, MDS Nurse, and the Pharmacist. MD stated she takes part in monthly resident medication reviews at the facility but was on vacation in August and did not participate that month. MD stated Resident 50's medications had not yet been reviewed by the Psychotropic IDT.

During an interview with Registered Nurse B (RN B) on 8/29/24 at 3:12 pm, RN B stated Resident 50 was living at home prior to admission to the facility, but Family Member 1 (FM 1) can't handle his increasingly aggressive behaviors of hitting, spitting, smearing, and eating his own feces, and he was admitted to the facility on hospice. RN B stated she evaluated Resident 50 twice weekly, and he was more calm. RN B stated he used to hit and spit, but staff said he was not doing that as much. RN B stated family is happy that his behaviors are improving.

During an interview with CPH on 8/29/24 at 3:45 pm, CPH stated he checked medications and reviewed order input for appropriateness and accuracy of orders when residents were admitted , checked that allergies were entered correctly, that psychotropic medications had behavior and side effect monitoring ordered, and that no drug-drug interactions (reaction between drugs, often negative) were likely to occur. CPH stated the contraindications (reasons against doing something) of Seroquel use in elderly residents with dementia, particularly when used in combination with donepezil, were not clear and that there was positive data supporting the use of antipsychotics for dementia symptoms. CPH stated, A lot of doctors use it for these symptoms. CPH verified that as of this interview (50 days after admission), the Psychotropic Interdisciplinary Team (IDT - a team with members from different disciplines who work together to set goals and make care decisions) had not yet reviewed Resident 50's medications for appropriate indications of use and/or GDR.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Yuba City Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1220 Plumas St Yuba City, CA 95991	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Administrator (ADM), ADM in Training (AIT), and DON on 8/29/24 at 4:34 pm, DON acknowledged striking behaviors were observed prior to admission on 7/10/24, and the indication for use of Seroquel (agitation AEB striking out during care) was taken from hospice orders. The DON stated the Psychotropic IDT would review Resident 50's medication regimen for unnecessary psychotropic medications and potential reduction of dose or removal of medications from his regimen. DON stated MD would do the psychotropic review and noted that if a resident was admitted with hospice, they must also review the medications with hospice. DON stated Resident 50's psychotropic medications had not been reviewed yet but that he was up for evaluation of Gradual Dose Reduction at the next Psychotropic IDT meeting in October. DON stated Psychotropic GDRs were performed monthly in the facility, but residents' medications were re-evaluated quarterly. DON stated a resident-specific psychotropic medication review would be performed the quarter after their admission. DON stated she didn't want to mess with the dose from admission orders for Seroquel until Resident 50 was settled. DON stated Resident 50 safely wanders but was easily distractible. DON stated she would make recommendations based on the quarterly meeting. DON stated CMS guidelines wouldn't flag for 100 days. During observation of Resident 50 in his room on 8/30/24 at 8:31 am, Resident 50 was lying on his right side, resting quietly, eyes closed, in a dimly lit room. During an interview with LN A on 08/30/24 at 08:40, LN A stated Resident 50 was usually calm but had one episode of wandering yesterday and was given a dose of lorazepam. LN A stated she did not believe Resident 50 was a danger to himself or others. LN A stated Resident 50 was sleepy this morning, but not too much, and he was not too sedated to eat breakfast.

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F 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure medication error rates are not 5 percent or greater.

49418

Based on observation, interview, and record review, the facility failed to ensure the medication error rate did not exceed 5 percent for two of six sampled residents (Residents 25 and 216) when:

1. For Resident 25, Licensed Nurse D (LN D) administered one oxybutynin extended-release (ER) 5 milligrams (mg - a unit of measure) tablet rather than the ordered oxybutynin chloride 5 mg, an immediate-release (IR) tablet, to treat overactive bladder.

2. For Resident 216, LN D did not administer scheduled or as-needed pain medications when Resident 216 stated his pain was 10 on a scale of 1 to 10 (1 being the lowest pain, 10 being the highest).

These failures resulted in two medication errors identified out of 29 opportunities, resulting in a medication error rate of 6.9 percent, with the potential for adverse health consequences from medication toxicity effect and unaddressed pain.

FINDINGS:

1. During a review of Resident 25's medical records, the record indicated Resident 25 was admitted in 10/2023 with diagnoses of unspecified symptoms of the genitourinary system (organs of the urinary and reproductive systems) and enlarged prostate.

During observation of medication administration on 8/28/24 at 8:42 am, LN D prepared and administered Resident 25's medications, which included removing one tablet from a blister pack (medication packaging), packaged by the pharmacy, labeled oxybutynin ER 5 mg tab - take 1 tablet three times daily for overactive bladder.

Reconciliation of the medication administration observation with Resident 25's Order Summary Report, dated 8/29/24, indicated an active order for oxybutynin chloride oral tablet 5 mg, to give one tablet by mouth three times a day for overactive bladder. The order was placed on 6/1/24 with a start date of 6/1/24.

During an interview with the Registered Pharmacist (RPH) on 8/28/24 at 12:36 p.m., RPH reviewed Resident 25's oxybutynin order. RPH stated the medication was first ordered 6/1/24 had been filled three times. RPH acknowledged the order indicated oxybutynin IR formula was to be given three times a day, not the extended-release formula. RPH stated, This is a medication error. RPH stated oxybutynin 5 mg ER should only be given once daily, not three times a day, and noted it was done incorrectly.

Review of Resident 25's Medication Administration Record, dated 8/1 to 8/31/24, indicated oxybutynin ER 5 mg was administered 83 times in 8/2024.

During concurrent observation of Resident 25's oxybutynin blister pack, review of Resident 25's active medication orders, and interview with LN D on 8/28/24 at 2:52 p.m., LN D acknowledged that the oxybutynin ER administered was not the same as the oxybutynin IR order.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 8/29/24 at 11:38 am, the DON stated she had written a medication error report and notified the Medical Director (MD) of the oxybutynin error. During an interview with the Medical Director (MD) on 8/29/24 at 3:05 p.m., the MD stated, We all play a role in preventing medication errors and discrepancies: MD and DON who review residents' medications, the Minimum Data Set (MDS - information gathered from assessing and monitoring residents in Medicare- or Medicaid-certified nursing homes) Nurse/Coordinator, pharmacy staff, and nursing staff who administer medications. During an interview with the Consultant Pharmacist (CPH) on 8/29/24 at 3:45 p.m., the CPH stated it was interesting that oxybutynin ER was sent from the pharmacy. CPH stated the medication error should have been noticed by in-house pharmacists. CPH stated the ER formula would take longer to metabolize (break down) and would stay in Resident 25's system longer than the IR formula. CPH stated he agreed with the MD's order switch to oxybutynin IR and monitor Resident 25 for potential adverse effects of receiving the longer-acting ER formula three times a day for three months (6/1 to 8/29/24). A review of facility document prepared by CPH titled Consultant Pharmacist's Medication Regimen Review: Listing of Residents Reviewed with No Recommendations, dated 7/2024, indicated Resident 25's medication regimen was reviewed and did not require any recommendations. A review of facility document titled Job Description: Licensed Practical Nurse (LPN) Licensed Vocational Nurse (LVN), undated, indicated licensed nurses are responsible for reviewing residents' charts for medication orders as necessary. A review of Policy and Procedure (P&P) titled Administering Medications, dated 10/2023, indicated: A. Medications are administered in accordance with prescriber orders, including any required timeframe. B. The person administering the medication verifies the resident's identity, then checks the label to verify the right resident, right medication, right dosage, right time, and right method of delivery (route) before giving the medication. C. If a dose is believed to be inappropriate or excessive, the person preparing and administering the medication will contact the resident's Attending Physician/Nurse Practitioner or the facility's MD to discuss concerns. 2. A review of Resident 216's medical record indicated Resident 216 was admitted in late 8/2024 with diagnoses of muscle weakness, repeated falls, fractured lumbar vertebrae (bones that protect the lower spinal cord) and multiple rib fractures, dementia (loss of brain function such as memory, language, problem solving and other thinking abilities), spondylosis (a degenerative spinal condition that causes pain and discomfort), and spinal stenosis (narrowing of the spinal canal that puts pressure on the cord and nerves causing pain, numbness, and weakness). The MDS Brief Interview for Mental Status (BIMS - Section C assessing cognitive function) had not yet been performed as Resident 216 was a new admit. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Nursing Note written by LN C, dated 8/28/24 at 9:04 am, indicated Resident 216 had his toes run over by a wheelchair this morning, but resident did not appear in pain. During observation of medication administration on 8/28/24 at 9:15 am, LN C stated Resident 216 bumped his foot and asked LN D if Resident 216 could have Tylenol. Resident 216 was wearing socks on his feet, seated in a wheelchair, and observed to rock back and forth, head in his hands, rubbing his left side, and making facial grimaces. LN C asked Resident 216 multiple times to rate his pain on a scale of 1 to 10; the pain scale was not explained to the resident, who appeared to be confused by the question. Resident 216 stated, I don't know, 10. LN D reviewed Resident 216's medication list and stated Resident 216 had received a dose of scheduled Tylenol that morning, and the only medication available was oxycodone (an opioid pain-relief medication for moderate to severe pain). LN D again asked Resident 216 to rate his pain on a scale of 1 to 10, and Resident 216 replied, I don't know. No medication was given, and Resident 216 was taken away by LN C. During an interview with LN C on 8/28/24 at 10:51 am, LN C stated she brought Resident 216 to LN D because he hit his toe on his wheelchair and was in pain. LN C stated he also fell recently and had pain from fractured ribs. LN C acknowledged Resident 216 did not receive any pain medication and stated he wasn't showing pain. Reconciliation of the medication administration observation with Resident 216's Order Summary Report, printed 8/29/24, indicated active orders placed 8/25/24 to include: A. No bending, lifting, twisting due to left-side rib fracture. B. Monitor for pain every shift using Scale 0 to 10 (0 no pain, 1 to 2 least pain, 3 to 4 mild pain, 5 to 6 moderate pain, 7 to 8 severe pain, 9 to 10 very severe/horrible/worst pain). C. Record non-pharmacological pain interventions every shift using 0 to 10 scale (0 no non-drug intervention needed, 1 repositioning/limb elevation, 2 reassurance/emotional support, 3 distraction/diversionary activities, 5 exercise/range of motion/ambulation/stretching, 6 deep breathing/relaxation, 7 guided imagery/meditation, 8 laughter/socialization, 9 aromatherapy). D. Resident does not have the capacity to make his decisions related to dementia. E. Tylenol 500 mg, two tablets by mouth every 8 hours for pain. F. Lidocaine patch (applied to skin in painful areas for pain relief) 4 percent applied to left side in the morning for rib pain; remove per schedule. G. Lidocaine patch 4 percent applied to low back in the morning for lower back pain; remove per schedule. H. Oxycodone oral tablet 5 mg, one tablet by mouth every four hours as needed for pain 6 to 10 for three days (8/28/24 at 9 pm). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 216's Medication Administration Record (MAR), dated 8/1 to 8/31/24, printed 8/29/24 at 12:52 pm, indicated Resident 216 refused all ordered lidocaine patches to left side and low back since admission; received Tylenol 10 times since admission but refused scheduled doses at 1 pm on 8/25 and 8/28/24; denied having pain 10 times since admission, with one report of 1 out of 10 pain on morning shift 8/28/24; nonpharmacological pain interventions of repositioning/limb elevation seven times and rest period/quiet environment 11 times since admission; and oxycodone 5 mg was given three times for severe pain 7 out of 10 on 8/26/24 at 7:24 am, 8/26/24 at 9:55 pm, and 8/28/24 at 5:08 pm. During concurrent interview with LN D and review of Resident 216's active orders on 8/28/24 at 2:52 pm, LN D stated Resident 216 had complained of left rib pain but had been refusing pain medication. LN D stated he did not give Resident 216 oxycodone for pain at 9 am because the resident couldn't give him a pain scale and LN D didn't think [Resident 216] was in pain. LN D acknowledged an order for lidocaine patches (scheduled for placement at 9 am) was available for pain and was not offered. LN D acknowledged Resident 216 had received only one dose of Tylenol for pain relief on 8/28/24. During an interview with LN C and LN D on 8/28/24 at 3:08 pm, LN C stated the protocol when residents refuse ordered medications is to ask the resident three times to take the medication, explain the risks and benefits, and if the resident still refuses, the doctor will be informed. LN C and LN D acknowledged they had not notified anyone that Resident 216 had frequently refused pain medications since admission. During concurrent observation and interviews with Resident 216 and Activities Assistant 1 (AA 1) on 8/28/24 at 3:17 pm in the dining area, observed Resident 216 sitting in a wheelchair near other residents during Activities (Bingo). Resident 216 was not participating but was observed fidgeting with the drawstring of his sweatpants, a plastic bracelet on his wrist, and lifting his T-shirt to intermittently rub his left side. When questioned about pain, Resident 216 stated his side hurt and pointed to his left ribs. Informed Resident 216 he had pain patches that could be applied by nursing staff. Resident 216 stated he needed to remove the patch from his wrist and took off his bracelet. AA 1 stated she believed Resident 216 was in pain because he had been verbalizing ow and grimacing throughout the activity. During an interview with the DON on 8/29/24 at 11:38 am, discussed the observation of Resident 216, LN C, and LN D on 8/28/24 at 9:15 am, with the result being no pain medication given. The DON stated, That's so frustrating. The DON stated she would provide education to nursing staff regarding the Pain Assessment in Advanced Dementia Scale (PAINAD - an assessment tool that monitors dementia/nonverbal residents for labored breathing, moaning/groaning, facial expressions, tense body language, and consolability). During an interview with DON, Administrator (ADM), and Administrator in Training (AIT) on 8/29/24 at 4:34 pm, the DON stated the MD was here 8/28/24 and was made aware that not all pain medications were being administered to Resident 216 despite indications of pain. The DON again stated she was frustrated that nursing staff did not recognize Resident 216's nonverbal indications of pain and would re-educate staff to the PAINAD scale. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Pain Assessment and Management, dated 4/2024, indicated, The purpose of this procedure is to help the staff identify pain in the resident . Observe the resident for signs and symptoms of pain . Possible Behavioral Signs of Pain: (a) verbal expressions of pain, (b) facial expressions such as grimacing, frowning . Assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive (mental) level . Implement the medication regimen as per physician's orders . The Interdisciplinary Team (IDT - a group of professionals who work in different disciplines and address common goals, issues, and/or concerns for each resident), including a physician, shall reconsider approaches and adjust if indicated to meet any further pain needs. A review of P&P titled Change in a Resident's Condition or Status, dated 4/2024, indicated the nurse will notify the resident's physician/nurse practitioner/physician assistant when there has been a(an) refusal of treatment or medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49418 Based on observation, interview, and record review, the facility failed to ensure medications and medication supplies were stored and labeled in accordance with currently accepted professional principles when: 1. A discontinued medication was not removed and discarded from an active medication drawer in Medication Cart A (MC A), 2. Six multi-dose tubes of noncontrolled medicated creams (prescription medications with less risk of addiction and abuse) were in a facility supply basket in Treatment Cart 1 (TC 1) without patient-specific labeling, 3. A used oral medication syringe was affixed with a rubber band to a bottle of liquid Keppra (anti-seizure medication) for reuse and was stored in a drawer of TC 1, 4. A bottle of glucose test strips was open and undated in MC A, 5. Eight loose pills were found in drawers and on the bottom of MC A, 6. A bottle of ketoconazole shampoo (antifungal) in TC 1 was being used on a resident despite an expiration date of 7/2023, and 7. An intravenous (IV) line filter (filters potential impurities to prevent infection) that expired 9/1/23 was in a medical supply drawer in Treatment Cart 2 (TC 2). 8. The Housekeeping Supervisor (HSK), an unlicensed staff member, maintained a key to the locked Medication Room. These failures had the potential for medication misuse, drug diversion, medication ineffectiveness, and potential exposure to harmful pathogens (bacteria, viruses, fungi) from reused or expired supplies for all 58 residents. FINDINGS: 1. During concurrent observation of medication preparation and administration and interview with Registered Nurse A (RN A) on 8/27/24 at 11:10 am, RN A stated the facility had two large medication carts: Medication Cart A (MC A - North Wing near the nurses' station) and Medication Cart B (MC B - East Wing), and two Treatment Carts near the nurses' station: Treatment Cart 1 (TC 1) oral medications; medicated creams, ointments, liquids) and Treatment Cart 2 (TC 2 - IV medications and supplies). Observation revealed a pharmacy-labeled baggie containing multiple packets of potassium chloride (a noncontrolled mineral supplement) 20 milliequivalents (mEq - a unit of measure) in MC A. The label indicated the potassium order had been discontinued. RN A acknowledged discontinued medications should have been removed from active medication areas. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Licensed Nurse C (LN C) on 8/27/24 at 11:23 am, LN C reviewed the potassium order and stated the prescription was filled by the pharmacy on 6/5/24 but was discontinued by the physician on 6/7/24. LN C verified the medication should have been removed from MC A. During an interview with the Director of Nursing (DON) on 8/29/24 at 11:38 am, the DON acknowledged discontinued medications should not be mixed with active medications and verified the potassium packets should have been removed from MC A and properly discarded. A review of Policy and Procedure (P&P) titled Discarding and Destroying Medications, dated 10/2023, indicated medications will be disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste, and controlled substances . Both controlled and non-controlled substances may be disposed of in a medication collection receptacle at the facility. A review of P&P titled Storage of Medications, dated 10/2023, indicated the facility stores all drugs and biologicals (D&Bs - a vaccine or drug created from biological sources) in a safe, secure, and orderly manner . Discontinued, outdated, or deteriorated D&Bs are placed in designated appropriate bins for destruction. 2. During concurrent observation of contents of locked TC 1 and TC 2 and interview with Licensed Nurse E (LN E) on 8/27/24 at 11:35 am, observed six tubes of prescription-strength medications in a basket without patient-specific labeling: A. Gentamicin sulfate ointment 0.1 percent (% - a unit of measure; an antibiotic that treats bacterial skin infections), B. Santyl ointment 250 units per gram (units/gm - a unit of measure; used to remove damaged tissue from wounds), C. Nystatin ointment 100,000 units/gm (treats fungal or yeast infections on the skin), D. Ketoconazole cream 2% (treats fungal or yeast infections on the skin), E. Triamcinolone acetonide cream 0.5% (reduces swelling and itching from eczema, allergies, rashes), and F. Mupirocin ointment 2% (an antibiotic that treats bacterial skin infections). Observation revealed the unlabeled medications were mixed with active, labeled medications. LN E stated the unlabeled tubes were facility supply that had once been prescribed to specific residents, but the labels had been removed and placed in TC 1. LN E acknowledged that medications should not be administered to residents without an order, and the unlabled tubes should have been removed from active medication areas. LN E acknowledged the risk to all residents from administering medications not ordered by a physician including potential adverse side effects, allergic reaction, and/or incorrect medication/dose. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 8/29/24 at 11:38 am, the DON verified unlabeled medications should not be administered to residents or mixed with active medications, and the unlabeled medications should have been properly removed from TC 1 and discarded. A review of facility document titled Job Description: Licensed Practical Nurse (LPN) Licensed Vocational Nurse (LVN), undated, indicated licensed nurses are responsible for reviewing residents' charts for medication orders as necessary. A review of Policy and Procedure (P&P) titled Administering Medications, dated 10/2023, indicated: A. Medications are administered in accordance with prescriber orders, including any required timeframe. B. The person administering the medication verifies the resident's identity, then checks the label to verify the right resident, right medication, right dosage, right time, and right method of delivery (route) before giving the medication. C. Allergies to medications and vital signs, if necessary, are checked/verified for each resident prior to administering medications. 3. During concurrent observation of contents of TC 1 and TC 2 and interview with Licensed Nurse E (LN E) on 8/27/24 at 11:35 am, observed a bottle of prescribed liquid Keppra (anti-seizure medication) in the bottom drawer of TC 2. An uncovered, sticky medication syringe (small hollow tube used to inject or withdraw liquids) that appeared used was secured to the bottle by a rubber band. LN E acknowledged a syringe that was placed in a resident's mouth should not be reused or stored in a drawer used by multiple staff members to prevent potential spread of infection to residents and staff. During an interview with the Director of Nursing (DON) on 8/29/24 at 11:38 am, the DON acknowledged concern that a disposable medication syringe was saved for reuse and stored uncovered in a TC 2 drawer. The DON stated education would be provided to the nursing staff. A review of P&P titled Storage of Medications, dated 10/2023, indicated the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. A review of Policy and Procedure (P&P) titled Administering Medications, dated 10/2023, indicated staff follows established facility infection control procedures for the administration of medications as applicable. 4. During concurrent observation of medication preparation and administration and interview with Registered Nurse A (RN A) on 8/27/24 at 11:10 am, observed an opened, undated bottle of glucose test strips (strips inserted into a device that measures blood sugar levels). RN A acknowledged she opened the bottle the day prior and should have written an Opened on date for discard one month after opening. During an interview with the Director of Nursing (DON) on 8/29/24 at 11:38 am, the DON acknowledged opened test strip bottles required an Opened on date per professional standards and manufacturer instructions to prevent use of an ineffective or less effective product. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During concurrent observation of medication preparation and administration and interview with RN A on 8/27/24 at 11:10 am, observed four loose pills in medication drawers of MC A and four loose pills under the drawers of MC A. RN A acknowledged loose pills create a risk for medication diversion and should have been disposed of/removed from the cart. During an interview with the Director of Nursing (DON) on 8/29/24 at 11:38 am, the DON verified loose pills should not be present in medication carts and should have been disposed of/removed to prevent medication diversion and/or misuse. A review of P&P titled Storage of Medications, dated 10/2023, indicated D&Bs are stored in the packaging, containers, or other dispensing systems in which they are received. Nursing staff is responsible to maintain medication storage and preparation areas in a clean, safe, and sanitary manner. 6. During concurrent observation of contents of TC 1 and TC 2 and interview with LN E on 8/27/24 at 11:35 am, observed a bottle of ketoconazole shampoo 2% with expiration date of 7/2023. LN E stated the shampoo was being administered to a resident but acknowledged the expired shampoo should have been discarded and the medication refilled to assure full effectiveness. During an interview with the Director of Nursing (DON) on 8/29/24 at 11:38 am, the DON verified that expired medications should not be administered to residents, and the expired shampoo should have been discarded and a refill requested. A review of P&P titled Storage of Medications, dated 10/2023, indicated discontinued, outdated, or deteriorated drugs and biologicals are placed in designated appropriate bins for destruction. 7. During concurrent observation of contents of TC 2 and interview with RN A on 8/27/24 at 11:45 am, observed an expired IV extension set with filter, dated 9/1/23. RN A acknowledged the product was expired and should not be used to administer medications to a resident. RN A stated the RNs and the DON clean the carts together to assure there are no expired products in the carts. During an interview with the DON on 8/29/24 at 11:38 am, the DON verified expired medication supplies should be discarded and replaced. During an interview with DON, Administrator (ADM), and Administrator in Training (AIT) on 8/29/24 at 4:34 pm, DON and ADM acknowledged all concerns above and stated education would be provided to nursing staff. 8. During concurrent observation of locked Medication Room and interview with Housekeeping Supervisor (HSK) on 8/27/24 at 12:36 pm, HSK unlocked the Medication Room for state surveyors with a key in her possession. HSK stated she is not a licensed nurse. Observation of the Medication Room indicated three Emergency Medication Kits (E-kit - a small amount of potentially dangerous medications for emergency situations when pharmacy services are unavailable) on the counter. The E-kits were secured with easily breakable plastic locks. Three unlocked cupboards contained potentially hazardous medications and supplements. During an interview with the Director of Nursing (DON) on 8/27/24 at 12:59 pm, the DON verified HSK was issued a key to the locked Medication Room and was not a licensed nurse. DON stated HSK was responsible for Central Supply and had a key to clean and stock supplies in the Medication Room. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to honor resident food preferences (food that was liked or disliked) and did not serve accurate portions when: 1. One out of five sampled residents (Resident 45) stated, the facility served food that Resident 45 did not like. 2. The facility did not provide the correct portion size of fish to residents during lunch on 8/29/24. These failures had the potential for unintended weight gain or unintended weight loss which could negatively impact resident health. Findings: 1. A review of the facility's undated policy and procedure (P&P) titled, Foods Brought by Family/Visitors, indicated, resident food choices would be honored when able. A review of Resident 45's undated Admission Record, indicated, admission to the facility on [DATE] with the diagnoses of gastro-esophageal reflux disease (stomach acid backs up into the tube that connected the stomach to the throat) and major depressive disorder (a sad mood). Resident 45 was her own responsible party (RP, made own decisions). A review of the Minimum Data Set (MDS, an assessment), dated 6/3/24, indicated, Resident 45 was cognitively intact (was able to think and remember). During an interview on 8/28/24 at 10:11 a.m., Resident 45 stated, not liking broccoli and the facility continued to serve broccoli. During a concurrent record review and interview on 8/29/24 at 3:39 p.m., with Registered Dietician (RD), Resident 45's Dietary Interview/Pre-Screen, dated 5/16/24, was reviewed. RD stated, the Dietary Interview/Pre-Screen, indicated, the facility's Certified Dietary Manager (CDM) conducted the dietary interview and documented Resident 45 had a dislike for broccoli, spinach, and greens. RD reviewed Resident 45's undated meal tickets (a paper ticket placed on each meal tray that described who the tray was for and included resident food dislikes). RD stated, the meal tickets indicated, Resident 45 did not have any food dislikes for breakfast, lunch, or dinner and should have. RD confirmed, the facility had not honored Resident 45's food preferences and should have. 2. A review of the facility's undated P&P titled, Meal Service, indicated, food provided to residents would be accurate. A review of an undated document titled, Recipe: Fish Fillet with Dill Sauce, indicated, the portion size of fish was three ounces. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Yuba City Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1220 Plumas St Yuba City, CA 95991	

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/29/24 from 11:10 a.m. to 12:56 p.m., meal prep and tray line (platting the meal) was observed. At 12:08 p.m., CDM was observed telling the [NAME] to utilize the scale and weigh portions of fish that was to be provided to residents for lunch. At 12:13 p.m., the [NAME] was observed putting fish onto the first plate that was assembled and there was no scale at the tray line for the [NAME] to weigh the fish. [NAME] continued to assemble plates of food without weighing the fish until 12:28 p.m., when the CDM was observed placing a scale near the cook. The [NAME] was observed platting various amounts of fish on to the plates, sometimes it was various sizes of multiple broken pieces of fish, one whole piece of fish, two whole pieces of fish, or two and a half whole pieces of fish. At 12: 56 p.m., all the resident lunch trays had been plated. [NAME] was observed weighing fish seven times during the entirety of the observation. CDM and RD confirmed, one portion size of fish was three ounces and [NAME] did not weigh each plated portion of fish. RD stated, [NAME] should weigh every couple of servings to gain a visual of what three ounces of fish looked like. CDM stated, [NAME] did not have enough time to weigh each portion of fish and should weight every couple of servings. CDM and RD both acknowledged, there was no way to assure accurate portion sizes were provided to the residents when [NAME] did not weigh each portion size.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the food and nutrition services department failed to provide food that was palatable (good temperature, tasted good) when residents from a confidential interview and 11 out of 22 sampled residents (Residents 5, 16, 28, 30, 37, 38, 43, 45, 57, 59, and 215) stated the food did not taste good and was cold. This failure had the potential for unintended weight loss. Findings: A review of the facility's undated policy and procedure titled, Meal Service, indicated, Temperature of the food when the resident receives it is based on palatability. The goal is to serve cold food cold and hot food hot. A review of the undated Admission Record, indicated, Resident 57 was admitted to the facility on [DATE] with the diagnoses of type 1 diabetes and type 2 diabetes (body could not regulate the amount of sugar in the blood). Resident 57 was her own responsible party (RP, made own decisions). A review of Resident 57's Minimum Data Set (MDS, an assessment), dated 7/20/24, indicated, Resident 57 had good cognition (ability to remember). During an interview on 8/27/24 at 3:37 pm, Resident 57 stated, sometimes the hot food was served cold and this morning the eggs and toast were cold. A review of Resident 45's undated Admission Record, indicated, admission to the facility on [DATE] with the diagnoses of gastro-esophageal reflux disease (stomach acid backs up into the tube that connected the stomach to the throat) and anemia (a lack of iron that caused the body to produce less red blood cells). Resident 45 was her own RP. A review of the MDS, dated [DATE], indicated, Resident 45 was cognitively intact. During an interview on 8/27/24 at 3:47 p.m., Resident 45 stated, the food reminded her of hospital food, did not like it, and the hot food was often cold. A review of the undated Admission Record, indicated, Resident 5 was admitted to the facility on [DATE], with the diagnoses of dysphagia (trouble swallowing) and oral impaired glucose tolerance (higher than normal blood sugar levels but did not meet criteria to be diagnosed with diabetes). Resident 5 was not her own RP. A review of Resident 5's MDS, dated [DATE], indicated, Resident 5 had good cognition. During an interview on 8/28/24 at 7:41 a.m., Resident 5 stated, the food was terrible, cold, and looked like my cat or dog went to the bathroom out in the yard. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview, during a taste test of the lunch that was served to residents on 8/29/24 at 1:05 p.m., Certified Dietary Manager (CDM) took the temperature of each food item on two test trays. The temperature of the regular textured French fries was observed to be 105 degrees ( ) Fahrenheit (F), was chewy, did not taste good, and was barely warm. The pureed (smooth and thick like pudding) textured French fries was observed to be 105 F and was barely warm, the pureed fish was observed to be 114 F and was barely warm. The pureed corn was observed to be 120 F and was barely warm. The facility's Food Service Support (FSS), CDM, and Registered Dietician (RD) were all present and participated with the taste test. FSS confirmed, the regular textured French fries were gummy. The CDM and RD both stated, there was not an issue with the temperature of the food during the taste test. RD stated the regular textured French fries tasted good and compared them to the quality of a well-known fast-food restaurant. Both RD and CDM stated, unawareness that the residents of the facility were unhappy with the taste and temperature of the food. 43031 A review of Resident 215's medical record indicated that Resident 215 was admitted on [DATE] with diagnoses that included, displaced fracture of shaft of left clavicle, Chronic Obstructive Pulmonary Disease (COPD, inflammatory lung diseases that block airflow and make it difficult to breathe), Cerebrovascular event history (stoke, blood flow to the brain is lost damaging brain tissue). The Minimum Data Set (MDS, Tool for evaluating and implementing a standardized assessment) Brief Interview for Mental Status (BIMS, Section C assessing cognitive function) score dated 8/18/24, indicated Resident 215 rates 15/15, which equates to being cognitively intact. During an interview on 8/27/24 at 1:00 pm, with Resident 215 in their bed in their room, Resident 215 stated Food is terrible. It is often cold. It tastes bad. They put on way too much salt. It is always the same. I don't want to always eat the same thing all the time. A review of Resident 16's medical record indicated that Resident 16 was admitted on [DATE] with diagnoses that included, Metabolic Encephalopathy (a brain dysfunction that occurs when the body's metabolism is affected and leads to chemical imbalances), COPD, and Respiratory Failure (not enough oxygen passes from the lungs to the blood). The MDS BIMS score, Section C assessing cognitive function) dated 8/5/24, indicated Resident 16 rates 15/15, which equates to being cognitively intact. During an interview on 8/28/24 at 11:30 am ,with Resident 16 lying in their bed in their room, Resident 16 stated, The food is not good. Everyday I get something that doesn't taste good or is a problem with my stomach issues. A review of Resident 28's medical record indicated that Resident 28 was admitted on [DATE] with diagnoses that included, Metabolic Encephalopathy, Squamous Cell Carcinoma of left ear (cancer), COPD. The MDS BIMS score dated 5/24/24, indicated Resident 28 rates 7/15, which equates to severe cognitive impairment. During an interview on 8/28/24 at 4:00 pm, with Resident 28 in their bed in their room, Resident 28 stated, Food is terrible, taste and texture. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a confidential interview on 8/29/24 at 1:30 pm, with Resident Council members, four of nine sampled residents stated that meals were often cold, especially for those eating in their rooms and last to receive trays, and meals are lacking in taste. One of nine sampled residents stated the food was visually displeasing, looks like a dog turd. Three of nine sampled residents concurred that slow eaters were not given enough time to eat, and their food would be removed. One of nine residents stated there was not enough food provided. 49934 A record review of Resident 30 indicated she was admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD, a lung disease that blocks airflow and makes it difficult to breathe), diabetes (a disease that occurs when the body doesn't produce enough insulin (a hormone that regulates sugar in the blood) or can't use insulin properly), end stage renal disease, (a medical condition where the kidneys permanently stop working) and is dependent on dialysis (process of removing excess water, chemicals, and toxins from the blood by a machine). Resident 30's Brief Interview for Mental Status (BIMS, evaluation of mental function), dated 08/05/2024, score was 10, which indicated a moderate mental impairment. Resident 30 is her own responsible party; she makes her own decisions. During an interview on 08/27/24 at 11:34 am, Resident 30 stated that the Food is crap! The chicken tastes like rubber! A record review of Resident 37 indicated she was admitted on [DATE] with diagnoses of a fracture at the right humerus, chronic kidney disease, and secondary parkinsonism (a condition that causes symptoms similar to Parkinson's Disease (a disorder that affects the nervous system and parts of the body controlled by nerves) but is caused by an underlying medical condition or external factor). Resident 37's Brief Interview for Mental Status (BIMS, evaluation of mental function), dated 08/12/2024, score was 15, which indicated no mental impairment. Resident 37 is her own responsible party; she makes her own decisions. During an interview on 08/27/24 at 10:51 am, Resident 37 stated that the Food is awful. It is way over-cooked! The veggies are mushy, potatoes are instant, breakfast is blah and it's the same thing every day- eggs and toast. 40425 A review of Resident 59's medical record indicated that Resident 59 was admitted on [DATE] with diagnoses that included, muscle weakness, difficulty walking, infection, and inflammatory reaction due to other internal joint prosthesis. During an interview on 08/27/24, at 1:30 p.m., with Resident 59, Resident 59 stated, The food is terrible and doesn't taste good. It has no flavor. A review of Resident 38's medical record indicated that Resident 38 was admitted on [DATE] with diagnoses that included, diabetes, irregular heartbeat, muscle weakness, and difficulty walking. During an interview on 8/27/24, at 1:45 p.m., with Resident 38, Resident 38 stated, The food has no flavor, and it doesn't taste good. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 43's medical record indicated that Resident 43 was admitted on [DATE] with diagnoses that included, Depression, muscle weakness, difficulty walking, and dementia. During an interview on 8/27/24, at 2:15 p.m., with Resident 43, Resident 43 stated, the food sucks.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45315 Based on observation, interview, and record review, the facility failed to maintain equipment in good repair when the pots and fry pans had a black build up on the outside, the inside protective layer of the fry pans was missing (caused metal to be exposed), and one fry pan had a thick, black buildup of material on the inside where food was cooked. This failure had the potential to contaminate food and cause a decline in resident health. Findings: The facility's undated policy and procedure (P&P) titled, Sanitation, indicated, all equipment would be kept clean and in good repair. During a concurrent observation and interview on 8/29/24 at 11:10 a.m., located in the facility's kitchen, with the Certified Dietary Manager (CDM), the pots and fry pans were observed. The pots and fry pans had a black build up on the outside, the protective layer on the inside of the fry pans was missing, and one fry pan had a thick, layer of black residue on the inside, where resident food was cooked. CDM confirmed the findings and stated, CDM had ordered new pots and pans last week. A copy of the invoice that included the order date was requested. During a concurrent interview and record review on 8/29/24 at 12:00 p.m., CDM provided an email, dated 8/29/24, that included an order for two fry pans and four sauce pots. There was no date on the invoice that indicated the order had been placed last week.