

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/13/2025
NAME OF PROVIDER OR SUPPLIER Yuba City Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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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. Based on observation, interview, and record review the facility failed to ensure the medication error rate was below 5% for 2 of 6 sampled residents (Resident 40 and Resident 4) when: 1. Registered Nurse (RN) B did not administer Resident 4's oral inhalation medication as ordered by prescriber.2. RN G administered Resident 44's medication not in accordance with the standards of practice.As a result, 2 errors were identified out of 26 opportunities for error during the observation of medication administration; the facility medication error was 7.69%.Findings:1. During an observation on 9/16/25 at 9:24 am, RN B was observed to prepare and administer Resident 4's morning medications which did not include a multidose inhaler, fluticasone furoate, umeclidinium, and vilanterol inhalation powder (combination of 3 medications used to treat shortness of breath), for oral inhalation use.During a reconciliation of the observation of medication administration with Resident 4's Physician Orders, indicated an order, dated 6/11/25, for fluticasone furoate, umeclidinium, and vilanterol inhalation powder for oral inhalation to be administered 1 puff inhale orally one time a day for Chronic Obstructive Pulmonary Disease (COPD, a condition involving constriction of the airways and difficulty or discomfort in breathing). A review of Resident 4's Medication Administration Record (MAR) indicated a dose of Resident 4's oral inhalation medication was marked given on 9/16/25 at 9 am.During an interview on 9/16/25 at 11:25 am, with RN B, RN B stated, I forgot to give that inhaler. RN B acknowledged that she had not given the medication even though the MAR was marked given.During an interview on 9/18/25 at 11:30 am, with the Director of Nursing (DON), the DON stated, she expected the nurses to follow the Physician Orders. The nurse should have given resident's oral inhalation in the morning as prescribed.During a review of the policy and procedure (P&P) titled, Administering Medications, reviewed October 2024, the P&P indicated, medications are administered in accordance with prescriber orders, and are administered within one hour of their prescribed time, unless otherwise specified.2. During an observation on 9/16/25 at 11:59 am, RN G was observed to prepare and administer Resident 44's noon insulin, medication used to treat high blood sugar levels. RN G took out a vial of insulin from the medication cart, shook it vigorously for few seconds, withdrew two units of insulin lispro, and administered two units to Resident 44.During a reconciliation of the observation of medication administration with Resident 44's Physician Orders, indicated an order, dated 9/15/25, Inject as per sliding scale: if 0 - 150 = 0 units;151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 -400 = 10 units, subcutaneously before meals for Diabetes Mellitus II (a chronic condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels).A review of Resident 44's MAR indicated a dose of two units of lispro insulin was administered on 9/16/26 at 12:00 pm.During an interview on 9/16/25 at 3:20 pm, with RN G, RN G stated she shook the insulin vial when she was preparing resident 40's insulin. RN G acknowledged the insulin was already dissolved and she didn't know why she felt the need to shake the vial prior to drawing up insulin. According to an online publication by Mayo Clinic, Mayo foundation for medical information and research (a non-profit, American Academic center focused on integrated healthcare, education, and research), titled proper use of insulin lispro, last updated August 2025, indicated do not shake the vial.During an interview on 9/18/25 at 11:30 am, with the DON, the DON stated she expects the nurses to administer all medications according to the professional standards of practice.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055092	Facility ID: 055092
		If continuation sheet Page 1 of 16

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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. Based on observation, interview, and record review, the facility failed to ensure medications were stored properly as specified by the manufacturers when the temperature of a medication refrigerator was out of range below the freezing point. This failure resulted in liquid medications to crystalize and become ineffective. Findings: During a review of facility's policy and procedure (P&P) titled, Storage of Medications, reviewed October 2024, the P&P indicated, drugs and biologicals are stored in a safe, secure orderly manner including drugs being stored in locked compartments under proper temperature and light. The policy did not include the proper temperature range for the pharmaceutical items stored in the refrigerator. During a concurrent observation and interview with the Director of Nursing (DON) on 9/16/25 at 12:24 pm, the temperature of the medication refrigerator in the medication room was 29 F (degree Fahrenheit: unit of measurement). There were multiple medications in the refrigerator including insulin (medication used to treat high sugar level) vials. There was visible ice to the back wall of the refrigerator. The DON verified the refrigerator temperature was 29 F and one insulin vial presenting with crystalline almost frozen appearance present in the refrigerator. The DON stated the normal temperature range for the medication refrigerator was 36 F to 46 F. A review of insulin vial's product label, the label indicated, store refrigerated at 36 F to 46 F. Do not freeze.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Medical Director (MD) and the resident was notified of a change in condition for one of three sampled residents (Resident 35) when Licensed Vocational Nurse (LN) J discovered exposed bone and a surgical screw in Resident 35's right lateral ankle wound . This failure had the potential to put Resident 35 at risk of infection and a decrease in quality of care. Findings: During a record review of facility policy titled Change in a Resident's Condition or Status dated October 2024, indicated The nurse will notify the attending physician when there has been a significant change in the resident's condition. specific instruction to notify the physician of changes in the resident's condition. Facility policy further indicated A 'significant change' of condition is a major decline or improvement in the resident's status that: Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. impacts more than one area of the resident's health status. Facility policy also indicated A nurse or healthcare provider will inform the resident of any changes in his/her medical care. During a record review of LN J's job description titled Job Description: Licensed Professional Nurse/Licensed Vocational Nurse (LPN/LVN) dated 2/2024, indicated to Notify the resident's attending physician and next-of-kin when there is a change in the resident's condition. LN J signed this document on 10/1/21. During a record review of facility job description titled Job Description: Treatment Nurse Registered Nurse (RN)/LVN/LPN dated 10/2016, indicated to Accurately observe wounds and pressure sores with prompt notification of physicians of lack of progress in healing or deterioration with the current treatment and or signs/symptoms of infection. Facility job description further indicated to Notify family and attending physician of significant treatments related issues regarding their residents including sudden and/or marked adverse changes in skin condition or wounds; report significant findings or changes in condition and potential concerns to RN Supervisor and/or Director of Nursing (DON). During a record review of Resident 35's admission record, she was admitted to the facility on [DATE] with diagnoses that included unspecified fracture of right lower leg (when there is a break in one or more bones of the right lower leg), disruption of wound (a condition where a previously closed wound reopens or separates), and dysphagia (a language disorder that affects a person's ability to understand, speak, read, or write). During a record review of facility document titled Wound Evaluation and Treatment dated 9/3/25 12:41 pm, indicated LN J evaluated Resident 35's wound and documented there was bone exposed on the right lateral ankle. Facility document indicated, Upon weekly skin assessment surgical incision on right lateral ankle is noted with 8-centimeter (cm) x 2 cm with opening in bottom of incision around 2.2 cm x 1.8 cm x 0.2 cm. Incision deteriorated and the bone is exposed on ankle. Continue treatment order to apply xeroform and wrap with kerlix wrap. During a record review of progress note titled eINTERACT Summary for Providers (SBAR - a tool used for communication between direct care staff and the resident's provider) dated 9/5/25 2:58 pm, indicated Nursing observations, evaluation, and recommendations are: . Resident noted with open wound on right lateral ankle. resident noted with exposed metal hardware on right lateral ankle about 2.5 cm x 2 cm x 0.3 cm. No drainage noted and metal hardware is exposed. Called orthopedic office and talked with a medical assistant. She stated Physicians' Assistant (PA) wrote down an order in chart that if metal hardware exposed to send resident out to emergency room for further evaluation. MD was in [facility] and made aware. During a concurrent observation and interview with Resident 35 on 9/18/25 at 10:47 am, Resident 35 stated LN J did not tell her that there was exposed bone on her right lateral ankle on 9/3/25. Resident 35 stated LN J told her she needed to go to a local acute care hospital on 9/5/25 for right lateral ankle wound evaluation and treatment because there was a screw sticking out. During an interview on 9/18/25 at 12:30 pm, with MD, MD stated she expected staff to notify her immediately of Resident 35's change in (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition. MD stated she was not aware LN J documented the discovery of exposed bone and orthopedic screw during the wound evaluation and treatment on 9/3/25. MD stated she expected to be notified on 9/3/25. MD confirmed LN J did not notify her of Resident 35's wound changes of condition until two days later on 9/5/25. During an interview on 9/18/25 at 1:11 pm, with LN J, LN J confirmed she documented exposed bone on 9/3/25. LN J stated she called Resident 35's orthopedist's office on 9/3/25, but it was late in the day, and no one answered. LN J confirmed she should have contacted MD immediately. LN J confirmed she did not notify the DON and should have. LN J stated she will notify MD immediately for future reference. During an interview on 9/17/25 at 9:30 am, with DON, DON confirmed LN J documented exposed bone on Resident 35's right lateral ankle on 9/3/25. DON stated LN J should have notified herself and the MD immediately. DON confirmed LN J did not notify MD until two days later on 9/5/25. DON confirmed 9/5/25 was when Resident 35 was sent to a local acute care hospital for wound evaluation per MD order. DON confirmed LN J did not follow facility policy for notification of change in condition.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop comprehensive care plans (a detailed, patient-centered document that summarizes a patient's medical, functional, and psychosocial needs and goals, outlining the interventions and resources needed to achieve them) for two of 18 residents (Resident 33 and 9) who's care plans were reviewed, when: 1. Resident 33 had a deep tissue injury (DTI, localized damage to the skin and tissue caused by pressure on an area for a long time) and there was no care plan developed. 2. Resident 9 was noted to be missing teeth on admission and there was no oral/dental care plan developed. These failures had the potential to decrease the physical, psychosocial, and emotional well being of Residents 33 and 9. Findings: 1. A review of the facility's policy titled, Care Plans, Comprehensive, reviewed August 2024, indicated the policy statement is A comprehensive care plan that includes measurable objectives to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. It further indicated at paragraph number 5, subset-e, The comprehensive care plan will: Incorporate identified problem areas. A review of Resident 33's clinical record indicated Resident 33 was admitted to the facility on [DATE] with diagnoses that included broken right ankle, and cirrhosis of the liver (a liver disease that destroys and scars liver tissue, which occurs over time and prevents the liver from functioning properly). Resident 33 was capable of making his own healthcare decisions. A review of the admission Minimum Data Set (MDS, a resident assessment tool), for Resident 33 dated 8/11/25, indicated that Resident 33 had no cognitive deficit, with a Brief Interview for Mental status (BIMS, assess a person's ability to think, reason and remember) score of 15 out of 15. During a concurrent interview and observation on 9/16/25 at 3:31 am, Resident 33 stated that he had fallen at home and broke his ankle. He stated that he had a cast and that the cast was recently replaced with a boot. It was observed that the resident had a Controlled Ankle Motion boot (CAM boot - a device designed to immobilize and support the ankle joint after an injury or surgery) on his right foot. During an interview on 9/17/25 at 1:11 pm, Resident 33 stated that he had a 'heel issue' on his right heel that was found the day his cast came off, which he thinks was on 9/9/25. During a concurrent interview with Licensed Nurse (LN) M and observation on 9/17/25 at 1:35 pm, LN M was observed doing wound care to Resident 33's right heel DTI. LN M confirmed that Resident 33 had a deep tissue injury on the right heel. During a record review of Resident 33's Care Plans initiated on 8/11/25, with a target date of 10/1/25 (a review of the individual care plans for a resident), the record indicated a Care Plan had not been initiated for Resident 33's DTI on the right heel. During a concurrent interview and record review on 9/18/25 at 12:42 pm, with the Director of Nursing (DON), Resident 33's care plan was reviewed. The DON confirmed that a Care Plan for Resident 33's DTI was not initiated. My expectations of the wound care nurse is to note changes in skin and to initiate Care Plans. The DON further stated that the wound care nurses did not follow policy and (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedure for wound care, nor were professional standards demonstrated due to the failure to follow proper protocol for wound care, which included appropriate documentation. 2. A review of the facility's policy titled Care Plans, Comprehensive reviewed August 2024, indicated A comprehensive care plan that includes measurable objectives to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 6. Areas of concern that are identified during the resident assessment will be evaluated. 7. Identifying problem areas and their causes and developing interventions that meet resident needs. During an interview on 9/16/25 at 3:29 pm, Resident 9 stated that she only had a few bottom teeth and that she needed dentures. A review of Resident 9's admission record indicated Resident 9 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD, a lung disease), depression, and stroke (when blood supply was blocked to an area of the brain causing cell death) which caused left sided weakness and paralysis. Resident 9 was able to make her own health care decisions. A review of Resident 9's MDS dated [DATE], Section C indicated BIMS assessment was performed. Resident 9's BIMS score was 14 (from a range 0-15), indicating she was able to reason, think and remember. Section L, Oral/Dental Status, indicated Resident 9 had no natural teeth in areas of her mouth. Section V (triggered care areas in which a care plan should be developed) indicated that the Oral/Dental care area was triggered. During a concurrent interview with the Social Service Director (SSD) and record review on 9/17/25 at 2:41 pm, Resident 9's admission Comprehensive Care Plan was reviewed. SSD stated that she had not developed an Oral/Dental Care Plan for Resident 9 and she should have due to the fact that Resident 9 only had bottom teeth and no other teeth. SSD stated We usually put in a care plan to watch for sores, and the goal is to be free from complications		

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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** Based on observation, interview, and record review, the facility failed to revise a comprehensive care plan (a detailed, patient-centered document that summarizes a patient's medical, functional, and psychosocial needs and goals, outlining the interventions and resources needed to achieve them) for one of seven residents (Resident 33) when Resident 33 had a medical equipment change from a cast to a Controlled Ankle Motion boot (CAM boot - a device designed to immobilize and support the ankle joint after an injury or surgery) on the right foot. This failure had the potential to decrease the physical, psychosocial, and emotional wellbeing of Resident 33. Findings: A review of the facility's policy titled, Care Plans, Comprehensive, reviewed August 2024, indicated, Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. A review of Resident 33's clinical record indicated Resident 33 was admitted to the facility on [DATE] with diagnoses that included broken right ankle, and cirrhosis of the liver (a liver disease that destroys and scars liver tissue, which occurs over time and prevents the liver from functioning properly). Resident 33 was capable of making his own healthcare decisions. A review of the admission Minimum Data Set (MDS, a resident assessment tool), for Resident 33 dated 8/11/25, indicated that Resident 33 had no cognitive deficit, with a Brief Interview for Mental status (BIMS, assess a person's ability to think, reason and remember) score of 15 out of 15. During a concurrent observation and interview on 9/16/25 at 3:31 pm, Resident 33 stated that he had a cast and that the cast was recently replaced with a boot around 9/9/25. It was observed that Resident 33 had a CAM boot on his right foot. During a record review of Resident 33's Care Plans initiated on 8/11/25, indicated that the Care Plan was not revised to reflect the change from a cast to a CAM boot on Resident 33's right foot. During a concurrent interview and record review on 9/18/25 at 12:42 pm, with the Director of Nursing (DON), Resident 33's care plan was reviewed. The DON confirmed that Resident 33's Care Plan for the right foot cast was not revised to reflect the implementation of the CAM boot. My expectations of the wound care nurse were to update Care Plans.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of two residents sampled (Resident 58) received services that met professional standards when Resident 58 did not have episodes of diarrhea documented in their medical record to provide a full description of a change of condition for Resident 58. This failure had the potential for Resident 58 to not receive proper care for her diarrhea which could cause decline in physical, mental and psychosocial health. Findings: A review of the facility's policy titled Change in a Resident's Condition or Status revised October 2024, indicated 5. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. A review of Resident 58's admission record indicated Resident 58 was admitted to the facility on [DATE] with diagnoses that included fracture of the right upper leg, muscle weakness, diabetes (high sugar in the blood), depression, anxiety and heart failure. Resident 58 made her own health care decisions. During an interview with Resident 58 on 9/16/25 at 10:01 am, Resident 58 was lying in bed and complaining of a sore bottom and stated I am having trouble with my bowels and am having lots of diarrhea today. During a concurrent interview with Licensed Nurse (LN) M and record review on 9/17/25 at 9:31 am, Resident 58's nursing progress notes were reviewed. LN M said there was a progress note on 9/16/25 at 11:48 am, which noted NP (Family Nurse Practitioner, FNP) gave verbal order for cbc (complete blood count, a blood test), and for c-diff (a stool test for a highly transmissible infection in the stool that causes diarrhea) test. Order noted and carried out. LN M stated she did not know why the FNP had ordered these tests and there was no documentation that Resident 58 was having diarrhea. During an interview with Resident 58 on 9/17/25 at 9:33 am, Resident 58 indicated she was having bad diarrhea and it started yesterday. Resident 58 said she had 8 episodes of diarrhea yesterday and was still having some today. During an interview on 9/17/25 at 9:35 am, Certified Nursing Assistant (CNA) L confirmed Resident 58 had four episodes of bad smelling liquid diarrhea during her shift on 9/16/25 from 6:00 am, to 2:30 pm, and was still having some today. CNA L said she informed the nurse yesterday. A review of Resident 58's Nursing Progress Notes from 9/15/25 at 4:51 pm, to 9/17/25 9:39 am, indicated there was no documentation concerning Resident 58 having diarrhea. During a concurrent interview with the Infection Preventionist (IP) and record review on 9/17/25 at 10:00 am, Resident 58's 9/16/25 and 9/17/25 progress notes were reviewed. The IP confirmed that there was no documentation concerning Resident 58's diarrhea. IP stated that there should have been a change of condition done for Resident 58 and documentation on what the stool looked like and there was not. During an concurrent interview with the Director of Nursing (DON) and record review on 9/17/25 at 10:24 am, Resident 58's Point of Care (CNA's documentation of resident's bowel movements) dated (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/16/25, was reviewed. DON confirmed that there was only one episode of a documented bowel movement for the day of 9/16/25. DON stated that each episode of diarrhea should have been charted by the CNA and it had not been. During an interview on 9/18/25 at 8:42 am, Family Nurse Practitioner (FNP) stated she had trouble getting a full picture of what was going on with residents because of the incomplete charting from the nurses. FNP indicated there was no documentation concerning diarrhea for Resident 58.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care and services were provided for two of three residents sampled for skin damage (Resident 49 and 58) when: 1. Resident 58 had developed redness to her bottom and it went unreported by staff and without appropriate treatments for healing. 2. Resident 49 developed a red rash around her mouth and it went unreported by staff and without appropriate treatments for healing. These failures had the potential for Resident 58 and 49's physical, mental, and psychosocial needs to go unmet. Findings: A review of the facility's policy titled Prevention of Pressure Ulcers/Injuries (pressure sores) reviewed October 2024, indicated Inspect the skin when performing or assisting with personal care or ADL's (activity of daily livings). Evaluate, report and document potential changes in the skin. A review of the facility's Certified Nursing Assistant (CNA) Job description, dated 2/2019, indicated essential duties included to report all changes in the resident's condition to the Nurse Supervisor/Charge Nurse as soon as practical. 1. A review of Resident 58's admission record indicated Resident 58 was admitted to the facility on [DATE] with diagnoses that included fracture of the right upper leg, muscle weakness, diabetes (high sugar in the blood), depression, anxiety and heart failure. Resident 58 made her own health care decisions. A review of Resident 58's Braden Scale (a tool to assess a patient's risk for developing pressure sores, skin damage that develop when pressure is applied to the same spot) for Predicting Pressure Sore Risk dated 9/16/25, indicated Resident 58 was At Risk for pressure sores. During an interview on 9/16/25 at 10:01 am, Resident 58 stated that her bottom had been sore for a couple of days. During a concurrent interview with Licensed Nurse (LN) A and record review on 9/17/25 at 9:23 am, Resident 58's September 2025 Treatment record was reviewed. LN A stated that Resident 58 had no identified sore on her bottom in her record, and no current treatment for her bottom. During an interview with LN M (who is also the treatment nurse) on 9/17/25 at 9:25 am, LN M stated that she wasn't aware that Resident 58 had a sore on her bottom at this time. During a concurrent observation and interview with CNA L on 9/17/25 at 9:35 am, Resident 58's bottom was observed having a two inch by one inch dark red area on her tailbone area. Resident 58 confirmed her tail bone was where her pain was. CNA L stated she noticed the red area to her tailbone yesterday but had not reported it to the nurse. During a concurrent observation and interview with the Director of Nursing (DON) on 9/18/25 at 1:05 pm, Resident 58's bottom was observed. The DON confirmed that there was a red area to Resident 58's tailbone and that there should have been an assessment and treatment for this area but that there was not. DON stated that the CNA's should have reported skin changes to the nurse when the change was noticed. 2. A review of Resident 49's admission record indicated Resident 49 was admitted to the facility on [DATE] with diagnoses that included heart failure, abdominal pain, kidney failure, dehydration and dysphagia (difficulty swallowing). Resident 49 made her own health care decisions. During a concurrent observation and interview with Resident 49 on 9/16/25 at 12:40 pm, Resident 49 was observed in her bed and she had a red rash around her mouth. Resident 49 stated that she had a red rash around her mouth and she was not sure why. During a concurrent observation and interview with Registered Nurse (RN) B and Resident 49, on 9/17/25 at 1:49 pm (a day later from last observation), RN B confirmed that she had noticed Resident 49's red mouth this morning during medication pass. RN B stated that she had not assessed Resident 49's rash or documented concerning this because Resident 49 said she had no pain. RN B and this Surveyor went to Resident 49's room and observed Resident 49 in her bed with a large red rash around her entire mouth. Resident 49 stated that her lips were numb and that her rash hurt. Resident 49 stated I wish it wasn't this way. During a concurrent interview with RN B and record review on 9/17/25 at 1:56 pm, Resident 49's September 2025 Physician treatment orders were reviewed. RN B stated that Resident 49 had no treatments ordered for her red rash around her mouth and that there was no documentation concerning her red rash and numb lips. During an interview on 9/17/25 at 2:05 pm, CNA E stated I (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	thought it (the rash) was something the nurses were aware of because it (the rash) was something that was there for a couple of days. I should have told the nurses about the rash when I noticed it. CNA E indicated skin assessments are done on shower days and new skin issues are relayed to the nurses. During a concurrent interview with the Medical Records Director (MRD) and record review on 9/17/25 at 2:14 pm, Resident 49's CNA Daily Body Check on Showers . assessment dated [DATE] for AM shift was reviewed. The assessment indicated no new or existing skin issues documented by CNA O. MRD confirmed that that there was no new or existing documented skin issues. During an interview on 9/17/25 at 2:18 pm, CNA O stated she had given Resident 49 a shower this day and she thought Resident 49 was wearing lipstick and had not mentioned it to the nurse but should have.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review the facility failed to ensure annual performance evaluations for three out of four Certified Nursing Assistants (CNA C, E, and F) were completed every 12 months. This had the potential for direct care staff not to provide quality of care and meet the needs of the residents. Findings:During a record review of facility policy titled Performance Evaluations dated September 2024, indicated A performance evaluation may be completed on each employee at least annually based on the hire date. Facility policy further indicated The supervisor and the evaluated employee should sign and date the evaluation form.During a concurrent interview and employee file review on 9/17/25 at 11:19 am, Payroll Personnel (PP) confirmed there were no annuals performance reviews completed for:1. CNA C, Date of Hire (DOH) 11/22/23, missing a 2024 annual evaluation.2. CNA E, DOH 3/29/22, missing a 2023 annual evaluation.3. CNA F, DOH 4/1/23, missing a 2024 annual evaluation.During a concurrent interview with Director of Nursing (DON) on 9/18/25 at 12:12 pm, CNA employee files were reviewed. The DON confirmed annual staff evaluations had not been consistent. DON verified she had been at facility for about a year and was trying to get caught up on annual staff evaluations.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain its infection prevention control program when: 1. One of one resident (Resident 58) sampled for Transmission Based Precautions (TBP) was suspected to have Clostridium Difficile (c-diff, a bacterium [germ], transmissible infection [easily spreads to another person], that causes an infection of the colon, the longest part of the large intestine. Symptoms can range from diarrhea to life-threatening damage to the colon) and no isolation precautions were initiated as per policy to prevent the spread of disease. This failure had the potential to spread c-diff to other residents and staff and cause severe illness and decline in health status. 2. One of two residents (Resident 10's) sampled for tube feedings, had a gastrostomy tube (G-tube, a feeding tube that delivers nutrition, fluids, and medications directly into the stomach thru a surgical created opening in the abdomen) Lopez valve (a three way stop cock that fits to the end of the G-tube to create a closed or open system) that was found to be filled with a dried, brown substance and had not been cleaned. This failure had the potential to allow bacteria to grow and cause an infection in Resident 10. 3. Blood pressure cuffs were shared between residents and were not cleaned and disinfected. This failure had the potential to allow the spread of infection between residents. Findings: A review of the facility's policy titled Clostridium Difficile revised October 2024, indicated, Measures are taken to prevent the occurrence of Clostridium difficile (CDI) infections among residents. Clostridium difficile infection is suspected in residents with acute, unexplained onset of diarrhea (three or more unformed stools within 24 hours). The primary reservoirs (places where they live) for c-diff are infected people and surfaces. Spores can persist on resident -care items and surfaces for several months and are resistant to common cleaning and disinfection methods. A review of the facility's policy titled Isolation-Categories of Transmission-Based Precautions revised October 2024, indicated Transmission-Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection: .and is at risk of transmitting the infection to other residents. Contact Precautions (wearing a gown and gloves upon entering a patient's room to prevent the spread of infection through direct or indirect contact) may be implemented for resident's known or suspected to be infected with microorganism (germs) that can be transmitted by direct contact with resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. A review of the Center for Disease Control's (CDC) site titled Transmission Based Precautions for health care providers, dated April 3, 2024, indicated Use contact precautions for patients with known or suspected infections that represent an increased risk for contact transmission. *Use Personal Protective Equipment (PPE, includes gowns, gloves, face masks) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning (putting on) PPE upon room entry and properly discarding before exiting the patients room is done to contain pathogens [germs]. 1. A review of Resident 58's admission record indicated Resident 58 was admitted to the facility on [DATE] with diagnoses that included fracture of the right upper leg, muscle weakness, diabetes (high sugar in the blood), depression, anxiety and heart failure. Resident 58 made her own health care decisions. A review of Resident 58's admission Minimum Data Set (MDS, a complete clinical assessment) dated (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/12/25, section H, Bladder and Bowel assessment, indicated that Resident 58 was always incontinent (unable to control) of her bowels. During a concurrent observation and interview with Resident 58 on 9/16/25 at 10:01 am, Resident 58 was lying in bed and stated I am having trouble with my bowels and am having lots of diarrhea today. Resident 58's room was observed and there was no isolation sign on the outside of the door, there was no PPE equipment outside the door, there was no garbage can near the door to discard potentially contaminated items. During a concurrent interview with Licensed Nurse (LN) M and record review on 9/17/25 at 9:31 am, Resident 58's nursing progress notes were reviewed. LN M said there was a progress note on 9/16/25 at 11:48 am, which noted NP (Family Nurse Practitioner, FNP) gave verbal order for cbc (complete blood count, a blood test), and for c-diff (a stool test for Clostridium Difficile, a highly transmissible infection in the stool that causes diarrhea) test. Order noted and carried out. LN M confirmed Resident 58 was being tested for c-diff. During an interview with Resident 58 on 9/17/25 at 9:33 am, Resident 58 indicated she was having bad diarrhea and it started yesterday. Resident 58 said she had 8 episodes of diarrhea yesterday and was still having some today. During a concurrent observation and interview on 9/17/25 at 9:35 am, Certified Nursing Assistant (CNA) L confirmed Resident 58 had four episodes of bad smelling liquid diarrhea during her shift on 9/16/25 from 6:00 am, to 2:30 pm, and was still having some today. CNA L said she informed the nurse yesterday. CNA L was observed going into Resident 58's room. CNA L put on gloves and then proceeded to take off Resident 58's brief (incontinent underwear that absorbs loose stool or urine) to exam her bottom. CNA L replaced Resident 58's brief, removed her gloves and did hand hygiene. CNA L confirmed that Resident 58 was not on contact isolation and that there was no isolation sign or Personal Protective Equipment (PPE) available to use except gloves, when giving cares to Resident 58. CNA L confirmed she had not been wearing a gown when providing care for Resident 58. During an interview with the Infection Preventionist (IP) on 9/17/25 at 10:00 am, 24 plus hours after the start of Resident 58's episodes of diarrhea, IP stated that if a resident was suspected to have c-diff and/or had loose stools we would put that resident on contact isolation right away. IP said that contact isolation consisted of putting on gowns, gloves, and a face shield outside of the room and putting large trash cans at the doorways before leaving the room to discard potentially contaminated items. IP stated that this should be done immediately when someone was suspected of having c-diff. IP indicated that she was unaware of Resident 58 having diarrhea yesterday and being tested for c-diff. The IP confirmed that Resident 58 should have been placed on contact isolation yesterday after having multiple loose stools and being tested for c-diff and she was not. During an interview with LN D on 9/17/25 at 10:33 am, LN D stated she was informed of Resident 58 having diarrhea on 9/16/25 around noon, and notified the Family Nurse Practitioner (FNP). LN D stated that when residents are suspected to have c-diff we are supposed to notify the IP right away and put the resident on contact isolation. LN D stated that she did not do that because it was a really busy day but she should have. During an interview with the FNP on 9/18/25 at 8:42 am, FNP stated that Resident 58 was found not to have had c-diff but when it was suspected, the facility should have put Resident 58 on contact isolation to prevent the spread of the disease if she would have had it and they did not. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A record review of Resident 10's admission record, indicated Resident 10 was admitted to the facility on [DATE] with diagnoses that included secondary parkinsonism (a progressive neurological disorder that affects movement, balance, and coordination that is caused by an underlying medical diagnosis), aphasia (inability (or impaired ability) to understand or produce speech, as a result of brain disease or damage), dysphasia (a language disorder that affects a person's ability to understand, speak, read, or write), and gastrostomy status (referring G-tube). During a record review of Resident 10's care plan dated 4/28/25, the care plan did not indicate any interventions for Resident 10's Lopez valve. During a record review of Resident 10's September 2025 Physician Orders, the orders did not indicate any orders or interventions for Resident 10's Lopez valve. During a concurrent interview with Resident 10 and observation on 9/16/25 at 9:31 am, Resident 10's Lopez valve was observed to have dried, brown substance in the main medication and food port as well as dried, brown substance on the three-way stopcock. Resident 10 stated the Lopez valve was not changed every day. Resident 10 stated staff changed it when they get around to it. During a concurrent interview with LN A and observation on 9/16/25 at 11:14 am, Residents 10's Lopez valve was observed. LN A confirmed Resident 10's Lopez valve had brown dried substance in the main medication and food port as well as dried brown matter on the three-way stopcock. LN A confirmed it needed to be changed due to the risk of infection to the resident. LN A stated Lopez valve was supposed to be changed by the cart nurse every day. LN A confirmed valve was probably not changed for days. LN A confirmed there was no documentation by staff that confirmed the Lopez valve had been changed in Resident 35's chart. LN A confirmed there was no physician order to change the Lopez valve every day or as needed. During a concurrent interview and observation on 9/16/25 at 3:26 pm, Registered Nurse (RN) B confirmed Resident 35's Lopez valve was not changed every day. RN B stated it was changed as needed. Residents 10's Lopez valve and observed and RN B confirmed that it had dried, brown substance in the main medication and food port as well as dried, brown substance on the three-way stopcock. RN B confirmed this was an infection risk for Resident 10. RN B stated this should have been monitored by staff and changed sooner. RN B stated he did not know if there was a facility policy or physician's order for Lopez valves. During an interview with Director of Nursing (DON) on 9/19/25 at 12:12 pm, DON confirmed Resident 10's Lopez valve should not be filled with a dried, brown substance. DON confirmed Resident 10 did not have a physician order to change the Lopez valve as needed. DON confirmed Resident 10 was at risk for infection with dried substance on the Lopez valve. 3. During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items, Surfaces and Equipment, dated September 2024, the P&P indicated, reusable items, will be cleaned and/or disinfected between residents and when surfaces are visibly soiled. During a medication pass observation with RN B on 9/16/25 at approximately 9:30 am, RN B used a blood pressure monitor to measure a resident's blood pressure inside the resident's room. The blood pressure monitor was then taken out of resident's room and parked outside in the hallway without being cleaned and disinfected. RN B moved on to the next resident on the list for morning medication pass. RN B used the blood pressure monitor on 3 different residents before disinfecting. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with RN B on 9/16/25 at 9:30 am, RN B acknowledged that the blood pressure monitor and cuffs were not cleaned or disinfected between residents. RN B stated, the expectation is that they are cleaned after each resident. During an interview on 9/18/25 at 11:30 am, the DON confirmed blood pressure monitoring equipment should have been cleaned after each resident use.		