STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055499	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Point Care Center	625 16th Street Lakeport, CA 95453

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interviews and record reviews, the facility failed to protect Resident 1's right to be free from verbal abuse when Resident 2 verbally abused Resident 1 by yelling profanities and calling her an expletive.These failures decreased the facility's potential to prevent mental anguish and emotional distress among residents.Findings:A review of Resident 1's admission record indicated admission to the facility in January 2026 with diagnoses which included anxiety disorder (excessive, persistent fear or worry that interferes with daily life) and depression (a mood disorder characterized by persistent sadness). Resident 1 was her own responsible party (RP, a person who can manage their own health and financial decisions).A review of Resident 2's admission record indicated admission to the facility in August 2025 with diagnoses which included depression. Resident 2 was his own RP.A review of Resident 1's Brief Interview for Mental Status (BIMS) score conducted on 11/5/25, indicated she had a BIMS score of 12 which meant she had moderate ability to think, reason, and learn.A review Resident 2's BIMS score conducted on 12/3/25, indicated Resident 2 had a BIMS score of 15 (no cognitive impairment).A review of Resident 2's progress notes indicated:On 12/25/25 at 2:06 a.m. indicated, [Resident 2] is aox4 [Alert and Oriented x4 is a term used to describe a resident's level of awareness. It means the resident is fully aware and can accurately identify four things: who they are (person), where they are (place), what it is (time), and what is happening around them (situation)] [Resident 2] in wc [wheelchair] and wheeled himself into [Resident 1's room] and started yelling at her to 'shut up, you don't need to be yelling for help if you don't need it.' [Certified Nursing Assistant] intervened and assisted [Resident 2] back to his room when he stated, 'suffocate the bitch.' Placed on alert charting for res to res [resident-to-resident] aggressor MD [doctor] .DON [Director of Nursing] notified .A review of Resident 1's progress notes indicated:On 12/31/25 at 8:39 p.m. indicated, [Resident 1] was at the nurse station watching a movie and yelling when .Another resident [Resident 2] came where [Resident 1] was residing and became agitated with her yelling. [Resident 2] became aggressive and started yelling 'Shut the fuck up bitch, there is no reason to be yelling on New Year's Eve, I'm going to choke you out. Somebody should choke you, [sic] I'm going to slap that bitch.' Writer [Licensed Nurse 1 (LN 1)] intervened and corrected aggressor [Resident 1] where he said, 'too late I already said it.' .DON/Administrator [ADM] notified .On 1/7/26 at 6:18 p.m. indicated, [Resident 2] as previously documented again came to the nurses [sic] station while [Resident 1] was sitting with [LN 1]. [Resident 1] was yelling as baseline and.[Resident 2] said 'shut up' [LN 1] tried to deescalate, and [Resident 2] continued 'shut up, I don't pay money to hear your bullshit. Tell her to shut up.'.[LN 1] said tried to redirect [Resident 2] into room, then [Resident 2] says 'I'll tell that bitch to shut up.' [Resident 1] got quiet.During a concurrent record review and interview on 2/9/26 at 11:40 a.m., LN 1 reviewed the progress note she documented on 1/7/26 and stated her documentation was accurate. LN 1 stated that on 1/7/26 at around 6:18 p.m., she was at Nurse Station 2 with Resident 1 when Resident 1 was yelling, Help me, help me (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but unable to say what she needed help with. LN 1 stated Resident 2 then came to Nurse Station 2 and told Resident 1 to shut up and called Resident 1 a bitch. LN 1 also acknowledged she reported the incident between Resident 1 and Resident 2 that occurred on 12/31/25. LN 1 stated she strongly believed the incident that occurred on 12/31/25 was verbal abuse.During an interview on 2/9/26 at 2:45 p.m., Resident 2 stated he heard Resident 1 yelling Help me every day. Resident 2 stated yelling for help meant somebody was having an emergency. Resident 2 stated he went to Resident 1 with the intention of making her shut up. Resident 2 stated Resident 1 was no longer at the facility.During an interview on 2/9/26 at 3:25 p.m., LN 3 acknowledged she was the nurse assigned to Resident 2 on 12/31/26. LN 3 stated Resident 1 looked scared and stated she was scared of Resident 2 after Resident 2 yelled at her and threatened to choke and slap her. LN 3 also stated she believed what Resident 2 stated was a threat of aggression.During an interview on 3/2/26 at 1:14 p.m., LN 2 acknowledged what was documented in Resident 2's progress notes on 12/25/25 and confirmed that was what happened.A review of a facility policy and procedure (P&P) titled, Elder/Dependent Adult Abuse, dated 5/29/25, indicated, The facility will protect the rights, safety and well-being of each resident regardless of physical or mental condition against any and all forms of abuse including freedom from neglect, exploitation.Abuse includes verbal [abuse].Verbal Abuse- Refers to any use of oral .or gestured language that includes threats and/or disparaging and derogatory terms, to or about residents .within hearing distance of any resident, regardless of their age, ability to comprehend, or disability; threats of harm; including saying things to frighten the resident.

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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. Based on interviews and record reviews, the facility failed to report an allegation of verbal abuse within two hours to the California Department of Public Health (CDPH) for one resident (Resident 1) of two sampled residents when Resident 2 yelled and threated Resident 1 on 12/25/25, 12/31/25, and 1/7/26.This failure decreased the facility's potential to ensure residents were protected against abuse.Findings:A review of Resident 1's admission record indicated she has anxiety disorder (excessive, persistent fear or worry that interferes with daily life) and depression (a mood disorder characterized by persistent sadness). Resident 1 was her own responsible party (a person who can manage their own health and financial decisions).A review of Resident 1's Brief Interview for Mental Status (BIMS) score conducted on 11/5/25, indicated she had a BIMS score of 12 which meant she had moderate ability to think, reason, and learn.A review Resident 2's BIMS score conducted on 12/3/25, indicated Resident 2 had a BIMS score of 15 (no cognitive impairment).A review of Resident 2's progress notes indicated:On 12/25/25 at 2:06 a.m. indicated, [Resident 2] is aox4 [Alert and Oriented x4 is a term used to describe a resident's level of awareness. It means the resident is fully aware and can accurately identify four things: who they are (person), where they are (place), what it is (time), and what is happening around them (situation)] [Resident 2] in wc [wheelchair] and wheeled himself into [Resident 1's room] and started yelling at her to 'shut up, you don't need to be yelling for help if you don't need it.' [Certified Nursing Assistant] intervened and assisted [Resident 2] back to his room when he stated, 'suffocate the bitch.' Placed on alert charting for res to res [resident-to-resident] aggressor MD [doctor] .DON [Director of Nursing] notified .A review of Resident 2's SBAR [Situation, Background, Assessment, and Recommendation] communication form dated 12/25/25 at 1:57 a.m. indicated, [Resident 2] entered a female resident's [Resident 1] room to tell her to stop yelling out help .[Resident 2] has history of behavior-yelling out at staff and residents, curing-using profanities .[Resident 2] .wheeled himself into [Resident 1's] room and started yelling at her to 'shut up, you dont [sic] need to be yelling for help if you dont [sic] need it' .[while] assisted [Resident 2] back to his room when [Resident 2] stated 'suffocate the bitch'.A review of Resident 1's progress notes indicated:On 12/31/25 at 8:39 p.m. indicated, [Resident 1] was at the nurse station watching a movie and yelling when .Another resident [Resident 2] came where [Resident 1] was residing and became agitated with her yelling. [Resident 2] became aggressive and started yelling 'Shut the fuck up bitch, there is no reason to be yelling on New Year's Eve, I'm going to choke you out. Somebody should choke you, [sic] I'm going to slap that bitch.' Writer [Licensed Nurse 1 (LN 1)] intervened and corrected aggressor [Resident 1] where he said, 'too late I already said it.' .DON/Administrator [ADM] notified .On 1/7/26 at 6:18 p.m. indicated, [Resident 2] as previously documented again came to the nurses [sic] station while [Resident 1] was sitting with [LN 1]. [Resident 1] was yelling as baseline and.[Resident 2] said 'shut up' [LN 1] tried to deescalate, and [Resident 2] continued ‘shut up, I don't pay money to hear your bullshit. Tell her to shut up.'.[LN 1] said tried to redirect [Resident 2] into room, then [Resident 2] says ‘I'll tell that bitch to shut up.' [Resident 1] got quiet.A review of a Report of Suspected Dependent Adult/Elder Abuse form (SOC 341) dated 1/8/26 indicated notification of the verbal abuse from Resident 2 toward Resident 1 was faxed to CDPH on 1/8/26 at 4:14 p.m.During a concurrent record review and interview on 2/9/26 at 11:40 a.m. LN 1 reviewed the progress note she documented on 12/31/25. LN 1 confirmed she reported the incident to the DON and ADM.During an interview on 2/9/26 at 10:44 a.m. the ADM stated he reported the incident that happened on 1/7/26 to CDPH. The ADM stated he was aware the timeframe for reporting alleged abuse was within two hours and acknowledged the incident that occurred on 1/7/26 was not reported (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	until the following day on 1/8/26 via fax. The ADM stated a call was not placed to CDPH prior to the faxed message.During a concurrent record review and interview on 2/9/26 at 3:25 p.m., LN 3 stated she texted the DON on 12/31/25 at 6:57 p.m. LN 3 notified them that Resident 2 went to the nurse's station and got in Resident 1's face, screamed at her to shut the fuck up and that someone should choke her out and he was going to slap that bitch [Resident 2] which was witnessed by LN 1. LN 3 indicated she was going to complete a SBAR form and asked the DON and ADM what else she needed to do regarding the incident. The DON replied that an SBAR was not needed, there was no change of condition, and to keep both residents separated. LN 3 then clarified that if an SBAR did not need to be completed then why did LN 2 complete the form when Resident 2 was aggressive toward Resident 1 on 12/25/25. LN 3 indicated she knew nurses were supposed to fill out the forms for allegations of abuse. The response she received from the DON was not to fill out the forms because it was yelling and no one was touched. LN 3 responded, It was [a] verbal threat to harm .During a concurrent record review and interview with the DON and ADM on 2/20/26 at 3:31 p.m., the DON verified that the incident which occurred on 12/25/25 involved Resident 1 and Resident 2. The DON and ADM both stated the LN 2 had not reported the incident that occurred on 12/25/25. The DON stated if the incident had been reported to her, she would have started an investigation. The DON and ADM both acknowledged they were made aware of the incident which occurred on 12/31/25 between Resident 1 and Resident 2 via text message from LN 3. The ADM stated he called the nurses and investigated. The ADM also acknowledged he had not reported this incident to CDPH because in the process of the investigation, he was made aware that the residents were together in one table and were okay. Both the DON and ADM confirmed that the initial text message by LN 3 sent to them on 12/31/25 indicated Resident 2 said to Resident 1, Someone should choke you and I'm going to slap that bitch.During an interview on 3/2/26 at 1:14 p.m., LN 2 stated acknowledged she completed the SBAR form and added the incident that occurred between Resident 1 and Resident 2 on the facility's 24-hour report log on 12/25/25. LN 2 stated the DON was supposed to review both the SBAR communication form and 24-hour report log every day. LN 2 stated the DON was aware of the incident that occurred on 12/25/25 because the DON had called her after the incident and instructed her not to use the word abuse in her progress notes.A review of a facility policy and procedure (P&P) titled, Elder/Dependent Abuse, dated 5/29/25, indicated, The facility will protect. [residents] from any type of abuse. Any mandated reporter who.has observed or has knowledge of an incident that reasonably appears to be any type of abuse.will report the known or suspected instance of abuse. as follows.All alleged violations-Immediately but not later than 2 hours.-involves any type of abuse.