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	04/02/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to readmit one of three sampled residents (Resident 1) after hospitalization, referencing prehospitalization behaviors despite no change in Resident 1's health care needs.This finding resulted in the resident being transferred to another skilled nursing facility after hospitalization, further away from family who could advocate for his needs. This had the potential to result in Resident 1 experiencing unnecessary disruption in his care, emotional distress, and a lack of continuity in treatment and services.Findings:During a review of Resident 1's Face Sheet (a summary of the patient's essential personal, clinical, and insurance information), the Face Sheet indicated Resident 1 was admitted to the facility with diagnoses including severe dementia with behavioral disturbance (often manifested as agitation, aggression, and delusions), hiatal hernia (a condition where the upper part of the stomach bulges into the chest), chronic pain, encephalopathy (a syndrome of overall brain dysfunction), anxiety (fear and worry that is both intense and excessive), insomnia (difficulty falling or staying asleep), cerebral palsy (a brain disorder that affects body movement and muscle coordination), and recurrent depressive disorder (a mental health condition characterized by repeated episodes of loss of interest and feelings of sadness).During a review of Resident 1's SBAR Communication Form and Progress Note, dated 2/05/26, the note indicated Resident 1 had uncontrolled pain and a change in mental status, and a transfer to ER (Emergency Room) was requested by the family.During a review of Resident 1's Hospitalist Discharge Summary dated 2/26/26, the Discharge Summary indicated, Patient is in stable condition for transfer to SNF today.During an interview on 4/2/26 at 11:39 a.m., Responsible Party (RP) stated Resident 1 was originally admitted to the facility on [DATE]. RP stated she visited Resident 1 while she was at the hospital and was very involved in her discharge planning. RP stated she wanted Resident 1 to return to the facility after her hospitalization, but the facility repeatedly refused. RP stated the hospital first requested Resident 1's readmission to the facility on 2/13/26 but it was something about the medications that made them unable to readmit her. RP stated despite the hospital physician adjusting the medications, the facility still would not allow Resident 1's return. RP stated Resident 1 had a 1:1 sitter (a staff who provides continuous, direct observation of a single patient in a care facility) prior to her hospitalization, but on 2/25/26, she was asked by the facility Administrator if she would be able to pay for a private sitter if they readmitted Resident 1. RP stated it was frustrating when she stated she could not afford a private sitter, and the facility continued to refuse Resident 1's readmission due to not being able to meet her needs without explaining what those needs were. RP stated Resident 1 was eventually transferred the next day, 2/26/26, to another skilled nursing facility. RP stated it was hard to make regular visits to Resident 1 at the other facility because it was a lot farther and was concerned about Resident 1's adjustment to the new and unfamiliar place.During a review of Resident 1's [GACH] Update Care Coordination Note, the note indicated phone calls to the facility on 2/18/26 and 2/19/26 regarding Resident 1's return. A review of Resident 1's Update Care Coordination Note, dated 2/20/26, indicated, [facility] re-evaluating the referral after med changes since yesterday and today declined to take the pt stating they ?could not meet her needs.' CM (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requesting to know which needs they are unable to meet. Further review of Resident 1's Update Care Coordination Note indicated an attempted call to the facility Administrator on 2/24/26 to discuss her return. A review of Resident 1's Update Care Coordination Note, dated 2/25/26, indicated the facility Administrator visited Resident 1 at the hospital, and upon meeting with the case management team, asked for additional information about Resident 1 to provide to his nursing consultant. The note further indicated, When asked on needs that they were unable to provide for patient or concerned about providing for the patient, question (sic) went unanswered. @1715 (At 5:15 p.m.) Spoke with. daughter. provided update. [Administrator] at [facility] had called and was pushing back to see if patients family would pay for a 24 hour sitter to be with patient in their facility. daughter expressed she also was unable to obtain clear answers regarding what care they were unable to provide for her and that she felt her questions were danced around and avoided . A review of Resident 1's Final Case Management Note, dated 2/26/26, indicated, . Spoke with [Administrator] of [facility] who stated at this time they are unable to accept the patient as they are unable to meet her needs. SW (Social Worker) inquired on (sic) what needs of the patient that they were unable to meet, [Administrator] stated ?her behaviors, and they are only going to get worse .'During an interview on 4/2/26 at 12:41 p.m., the Director of Nursing (DON) stated all residents were permitted to return to the facility after hospitalization. DON stated she was not aware of the specifics about Resident 1's transfer to the other nursing home.During an interview on 4/2/26 at 1:17 p.m., the Administrator stated the facility was unable to take Resident 1 back after her hospitalization because they could not manage her care and help her at their current level. The Administrator stated Resident 1's initial admission was intended for short-term care only, and her behavior had worsened over time. The Administrator stated the facility did not have a psychiatric or locked unit. When queried if Resident 1's hospital discharge summary indicated the need for a psychiatric or locked unit, the Administrator did not answer the question. The Administrator stated the decision they made at the time that based on their experience, they were unable to manage Resident 1's care. The Administrator stated he visited Resident 1 at the hospital once, after the facility was contacted that she was ready to be considered for readmission. The Administrator stated he tried to talk to Resident 1, and although not completely coherent, Resident 1 said she wanted to go back. The Administrator stated he did not see the change in Resident 1 he was looking for and was unable to take her back. The Administrator stated the refusal of Resident 1's readmission was a group decision, comprised of members from the corporate level. The Administrator stated the members were neither physicians nor nurses but were corporate staff. The Administrator stated he could not recall if a physician was involved or consulted in the decision to refuse Resident 1's return to the facility.During a review of the facility policy titled, Bed-Holds and Returns, dated 2/2026, the policy indicated, The requirement that residents be permitted to return to the facility following hospitalization. applies to all residents. Residents are not discharged unless: a. the discharge or transfer is necessary for resident's welfare, and the facility cannot meet the resident's needs. Following a hospitalization, residents whom staff are concerned about permitting to return due to their clinical/behavioral condition at the time of transfer are evaluated based on their current condition, not their condition when originally transferred.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide written notices of bed-hold policies for two of three sampled residents (Resident 1 and 2) wo were transferred from the facility.This failure placed the two residents at risk for unlawful discharge from the facility.During a review of Resident 1's Face Sheet (a summary of the patient's essential personal, clinical, and insurance information), the Face Sheet indicated Resident 1 was admitted to the facility with diagnoses including severe dementia with behavioral disturbance (often manifested as agitation, aggression, and delusions), hiatal hernia (a condition where the upper part of the stomach bulges into the chest), chronic pain, encephalopathy (a syndrome of overall brain dysfunction), anxiety (fear and worry that is both intense and excessive), insomnia (difficulty falling or staying asleep), cerebral palsy (a brain disorder that affects body movement and muscle coordination), and recurrent depressive disorder (a mental health condition characterized by repeated episodes of loss of interest and feelings of sadness).During a review of Resident 1's SBAR Communication Form and Progress Note, dated 2/5/26, the note indicated Resident 1 had uncontrolled pain and a change in mental status, and a transfer to ER (Emergency Room) was requested by the family.During an interview on 4/2/26 at 11:39 a.m., Responsible Party (RP) stated Resident 1 was originally admitted to the facility on [DATE]. RP stated she did not receive any written bed-hold notice, nor any paperwork, from the facility during Resident 1's transfer to the emergency room on 2/5/26.During a review of Resident 2's Face Sheet, the Face Sheet indicated Resident 2 was admitted to the facility with diagnoses including acute respiratory failure (a condition where the blood does not have enough oxygen levels), chronic kidney disease (progressive loss of kidney function), chronic pain, unspecified dementia, and congestive heart failure (long-term condition where the heart muscle could not pump effectively).During a review of Resident 2's Progress Notes, dated 3/19/26, the note indicated Resident 2 was transferred out to the [GACH] for periods of unresponsiveness and panicked rapid breathing.During an interview on 4/2/26 at 2:54 p.m., the Director of Staff Development (DSD) stated there were no written bed-hold notifications provided to the residents or their responsible parties during transfers. The DSD stated the residents, or their responsible parties, were notified of bed-hold policies verbally via phone calls.During a concurrent interview and record review on 4/2/26 at 2:56 p.m. with the Director of Nursing (DON), Resident 1's medical records were reviewed. DON stated there was no record that a written bed-hold policy was provided to Resident 1's RP for her ER transfer on 2/5/26.During a concurrent interview and record review on 4/2/26 at 3:07 p.m. with the DON, Resident 2's medical records were reviewed. DON stated there was no record that a written bed-hold policy was provided to Resident 2 for her [GACH] transfer 3/19/26.During an interview on 4/2/26 at 3:10 p.m., the DON stated bed-hold notices should be written. The DON stated they needed a lot of staff re-education and a review of their policies and procedures.During a review of the facility policy titled, Bed-Holds and Returns, dated 2/2026, the policy indicated, All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided with written notice about these policies at least twice: a. notice 1: well in advance of any transfer (e.g., in the admission packet); and b. notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours) .