

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055499	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Rocky Point Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 ensure one of four residents sampled for abuse, (Resident 1's) right to remain free from verbal abuse by Certified Nursing Assistant A (CNA A), when CNA A came to work under the influence of alcohol, acted erratically, and intimidated and yelled at Resident 1. This failure caused Resident 1 to feel frightened and concerned about retaliation from CNA A. A review of Resident 1's admission record indicated Resident 1 was admitted in 06/26, with diagnosis of Thoracic Vertebral Compression Fracture (occurs when a vertebral body in the middle or upper spine collapses, typically due to bone thinning or trauma, such as a fall). A review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 6/26/26, indicated Resident 1 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident with a scoring range of 0-7 indicating severe cognitive impairment, 8-12 indicating moderate cognitive impairment, and 13-15 indicating cognitively intact) score of 15, indicating no cognitive impairment. During an interview on 7/20/26 at 12:25 p.m., in Resident 1's room, Resident 1 reported, on 7/4/26 at approximately 10 p.m., she heard CNA A screaming and fighting with someone over the phone in the hallway very loudly. Resident 1 called out for CNA A to please be quiet. Resident 1 stated, CNA A then entered her room and ripped open her curtain, and proceeded to yell at her, What do want now! It's only 10 o'clock. Resident 1 stated when CNA A came around the side of the bed to turn off the call light, CNA A lowered her mask to say something rude, and Resident 1 could smell alcohol on CNA A's breath. Resident 1 stated, I was frightened, and now I worry CNA A might retaliate, I wish they could lock the front door. Resident 1 stated she had written down what had occurred right after it happened and gave it to the Administrator (ADM). Resident 1 stated the ADM addressed her concerns right away, and Resident 1 had not seen CNA A since. A review of a written statement by Resident 1 detailing the incident, dated 7/4/26 at 10 p.m., indicated Resident 1 yelled at CNA A, Who are you, and CNA A stated her name with a, crazed look. The written statement further indicated Resident 1 felt the whole incident was a, Nightmare, and Resident 1 was fearful of retaliation. During an interview on 7/20/26 at 2:54 p.m., with CNA B in the hallway, CNA B stated she arrived for her shift on 7/5/26, at approximately 2 a.m., and CNA A was acting strange, was very loud, argumentative, and smelled of alcohol. CNA B stated, while caring for Resident 1, Resident 1 told CNA B that CNA A had screamed and yelled at Resident 1, and Resident 1 was scared. A review of a written statement by CNA B detailing the incident, dated 7/5/26, indicated CNA A smelled of alcohol, had been asleep and not answering call lights, and was argumentative. It further indicated, while Resident 1 reported the verbal abuse to CNA B, Resident 1 began to cry and asked to speak to the charge nurse. During an interview on 7/20/26 at 3:03 p.m., with Licensed Nurse A (LN A) in the hall outside the Director of Staff Development's office, LN A stated Resident 1 reported to LN A later in the morning on 7/5/26, that CNA A had screamed and (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 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. Based on interviews and record reviews, the facility failed to ensure resident-centered care and services were provided, as ordered, for one of two sampled residents (Resident 2), requiring 1:1 (one-to-one) close supervision, when Patient Companion A (PC A) had fallen asleep during his shift, and Resident 2 was found by Licensed Nurse B (LN B) in a dangerous and vulnerable position with her chest and torso facing upwards and sideways across the bed, and with her legs hanging off of the bed and onto the floor. This failure to provide continuous supervision, as ordered, put Resident 2 at risk for slipping or falling which could result in a serious injury such as a fracture or head trauma. A review of Resident 2's admission record indicated Resident 2 was admitted in 03/26, with the diagnoses of Severe Vascular Dementia with Agitation (involves advanced brain damage from reduced blood flow, causing extreme restlessness, distress, and behavioral outbursts), Chronic Pain (lasting or recurring physical discomfort that continues for more than three to six months) and Chronic Kidney Disease (when kidneys are damaged and cannot filter blood properly, causing waste to build up). A review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 6/26/26, indicated Resident 2 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident with a scoring range of 0-7 indicating severe cognitive impairment, 8-12 indicating moderate cognitive impairment, and 13-15 indicating cognitively intact) score of 00, indicating severe cognitive impairment. A review of Resident 2's active Physician Orders indicated an order for a patient companion 24/7 (24 hours a day 7 days a week) started on 1/20/26. A review of Resident 2's current Care Plan Report indicated Resident 2 required a 1:1 attendant due to cognitive impairment, balance problems, vascular dementia, muscle weakness, incontinence, communication deficit, poor safety awareness, inconsolable yelling out and anxiety, and physical behaviors such as scratching and biting. Due to these disease processes and symptoms, Resident 2 was at risk for dehydration, high risk for falls and injury, medication effects and side effects, self-care deficit, skin breakdown and isolation. During an interview on 7/20/26 at 1:17 p.m., with Resident 2's Responsible Party (RP), the RP stated she had come to visit Resident 2 a few weeks ago late at night and found the male companion, sitting with Resident 2, fast asleep. The RP stated she informed the Director of Staff Development (DSD) of her concern over the phone the next day. A review of the facility staffing schedule, dated 7/6/26, confirmed PC A was assigned for 1:1 supervision for Resident 2 during the night and early morning shift. During an interview on 7/21/26 at 11:35 a.m., with LN B, LN B stated on the morning of 7/7/26, while giving report to the oncoming nurse, a Certified Nursing Assistant approached both nurses and told them to come to Resident 2's room right away. LN B stated when they entered Resident 2's room, PC A was fast asleep in the chair, and Resident 2 was in a dangerous and vulnerable position with her chest and torso facing upwards and sideways across the bed, and with her legs hanging off of the bed and onto the floor. LN B stated they woke up PC A to ask him how Resident 2 got into this position, PC A stated he did not know and left the room. LN B stated Resident 2 was not able to respond to their questions and had a, Petrified look on her face. LN B stated PC A was currently the only male companion staff during the night shifts. During an interview on 7/20/26 at 3:13 p.m., with the DSD in her office, the DSD stated she was notified of the incident on 7/7/26, over texts by both LN B and the oncoming nurse. The DSD stated she had no documentation of the incident or documentation of the education or disciplinary action with PC A at this time. The DSD stated a patient companion falling asleep did not meet her expectation, as patient companions were supposed to provide constant supervision, prevent accidents, and keep residents safe. A review of a facility document titled, Patient Companion Job (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Description, not dated, indicated, Essential job functions are to provide continuous observation of the resident by remaining with them at all times. Reports significant observations to appropriate clinical staff including, but not limited to Nurses, Charge Nurse, Director of Nursing, and Physicians. Maintain appropriate documentation, charts, and related records. Ensure the comfort of residents. A review of a facility policy titled, Disciplinary Action, dated 2001, indicated, Prompt and courteous attention to the needs of our residents, the following of established job descriptions, work assignments, infection control techniques, etc., must be our common concern. Anything less than professional behavior is not only inappropriate but is a hindrance to the well-being of all concerned.		