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	03/13/2026

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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, measurement and interview, the facility failed to ensure resident bedrooms met the minimum required 80 square feet of living space per resident for 23 out of 31 resident rooms. This failure decreased the facility's potential to ensure residents' were provided a comfortable living environment to support the dignity, privacy and safe mobility within the room.Findings: In an interview on 3/10/25 at 11:06 a.m., Resident 51 stated, the room is small for 3 people.In a concurrent observation and interview on 3/10/26 at 11:28 a.m., the Maintenance Director (MD) measured room [ROOM NUMBER] and confirmed each residents' living space was 7 feet by 8 feet. The MD stated, Is there a minimum [room] size for residents? I don't know. In an interview on 3/10/26 at 11:34 a.m., Resident 6 stated, The room's a bit small to maneuver in; I'm mainly out in the halls. In an interview with the MD on 3/11/26 at 8:19 a.m., MD confirmed all square footag provided on the facility map were correct and the numbers in circles were the amount of people that could reside in a room. He amended the rooms where the numbers were incorrect. In an interview on 3/12/26 at 2:27 p.m., the Administrator stated he was unaware each resident was to have 80 square feet of living space.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055499	A. Building B. Wing	03/13/2026

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 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 licensed nurses failed to ensure the medication rate was below five percent when five errors were observed during 34 medication passes, which resulted in a 14.71% error rate.This failure decreased the facility's potential to ensure medication was administered as ordered by the physician and decreased the expected efficacy of the medication. (Cross-reference F760)Findings:During a medication pass observation on 3/11/26 at 8:17 a.m., Licensed Nurse 2 (LN 2) administered the following medications to Resident 32:Glipizide (an oral medication used to manage blood sugar levels) 5 milligrams (mg-a unit of measure) by mouth two times per day. Give 30 minutes before meals; and,Basaglar kwik-pen(R) (a long-acting insulin used to manage blood sugar levels) Inject 20 units subcutaneously (into the fatty tissue layer located under the skin).During this observation, upon entry to Resident 32's room, a eaten breakfast tray was on Resident 32's overbed table. LN 2 gave Resident 32 all the oral medications to take, followed by the Basaglar kwik-pen(R) injection to Resident 32's right lower abdomen. LN 2 immediately withdrew the insulin pen and did not hold against Resident 32's skin per manufacturer's instructions.A review of Resident 32's physician orders, dated 1/31/26, indicated, Glipizide 5 mg by mouth two times per day.Give 30 minutes before meals.During a medication pass observation on 3/11/26 at 8:47 a.m., LN 1 administered one spray of fluticasone (a medication used to treat allergy symptoms) nasal spray to both nostrils of Resident 27.A record review of Resident 27's physician orders, dated 1/21/26, indicated Fluticasone Propionate Nasal Suspension 50 mcg/act [micrograms per inhalation]. 2 spray [sic] in both nostrils one time a day for allergies.During a medication pass observation on 3/11/26 at 4:12 p.m., LN 5 administered the following medications to Resident 6:Metformin (an oral medication used to manage blood sugar levels) 1000 mg.Humalog kwik-pen(R) (a short acting insulin used to manage blood sugar levels) Inject 4 units subcutaneously.During this medication pass observation, LN 5 administered Humalog kwik-pen(R) insulin to Resident 6 by injecting it into the left side of the abdomen. LN 5 held the insulin pen against Resident 6's skin for three seconds, LN 5 did not hold the insulin pen to Resident 6's skin as per manufacturer's instructions. Additionally, at the time of metformin administration to Resident 6, dinner trays had not yet been served.A record review of Resident 6's physician orders dated 1/5/26, indicated, Metformin 1000 mg. Give 1 tablet by mouth two times per day.give with breakfast and dinner.A review of the manufacturer's instructions for use of Basaglar kwik-pen(R) dated 8/26/22 indicated, Insert the Needle into your skin. Push the Dose Knob all the way in. Continue to hold the Dose Knob in and slowly count to 5 before removing the Needle.A review of the manufacturer's instructions for use of Humalog kwik-pen(R) revised July 2023 indicated, Insert the Needle into your skin. Push the Dose Knob all the way in. Continue to hold the Dose Knob in and slowly count to 5 before removing the Needle.A review of the facility's policy titled Adverse Consequences and Medication Errors, revised February 2025, indicated, A medication error is defined as.the administration of drugs which is not in accordance with physicians orders.or accepted professional standards.failure to follow.accepted professional standards.A review of the facility's policy titled Administering Medications, revised April 2025, indicated, Medications are administered in a safe and timely manner, and as prescribed.Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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	03/13/2026

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 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. Based on observation and interview, dietary staff failed to ensure palatability and nutritive value for 60 residents who were served food from the kitchen during the lunch meal on 3/11/26 when foods were held on the steam table for over 1.5 to 2 hours and the test tray of purred food and vegetables was found to be gummy and bland.These failures decreased the facility's potential to prevent weight loss and malnutrition among residents.Findings:A review of the resident council meeting minutes from June, July, October, and November 2025, indicated various complaints regarding poor food quality, texture of food was inedible, and being rushed during meals.During an interview on 3/10/26 at 2:37 p.m., Resident 46 stated the food was not of good quality and they cook the heck out of the vegetables.During an observation of meal preparation on 3/11/26 at 9 a.m., [NAME] 7 was observed opening a can of corn and placing its contents in a pot on the stove top to cook. [NAME] 7 placed the cooked corn on the steam table at 9:50 a.m. [NAME] 7 then prepared the gravy for the roast beef and the pureed roast beef adding thickener to obtain a pudding-like consistency. The pureed beef was then placed on the steam table at 10:30 a.m. Lunch was to be served at 12 p.m.During an observation of the Resident Council Meeting conducted on 3/11/26 at 10 a.m., residents who attended verbalized various food complaints which included poor quality, not palatable, and overall the food was not good.A test tray was completed on 3/11/26 at approximately 12:56 p.m. in the presence of the Corporate Registered Dietician (CRD). The meal consisted of regular and pureed textures of roast beef, scalloped potatoes, buttered corn and a bread roll. The regular textured buttered corn was bland. The pureed beef and corn were bland, the pureed potatoes and bread roll were bland and gummy. All the food appeared gray in color. The CRD stated they would look more closely at how the pureed foods were prepared.During an interview on 3/11/26 at 3:45 p.m. the Dietary Manager (DM) stated food was expected to be held on the steam table for approximately 45 minutes.A review of the facility's undated recipe for scalloped potatoes indicated three ingredients: scalloped potato mix, margarine, and hot water. The recipe did not include instructions to add any seasonings.A review of the facility's undated recipe for pureed cream style corn indicated two ingredients: canned creamed corn and thickener or frozen pureed corn. The recipe did not include instructions to add any seasonings.A review of the facility's policy titled Food and Nutrition Services revised October 2025 indicated, Each resident is provided with a nourishing, palatable.diet.A review of the facility policy & procedure titled, Food Service Temperature Control, not dated, indicated, Vegetable preparation. Vegetables should be prepared as close to serving time as possible.Care should always be taken to prevent destroying their nutritive value.In preparing commercially canned vegetables.Add the proper seasonings to the vegetables, and heat them to serving temperature as close to serving time as possible.Vegetables may be more appealing by varying their garnishes and seasonings.Seasonings.They are added to food to develop flavors, which make the food more interesting and add variety to the diet. Seasonings include herbs, spices, extracts, and flavors.

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	03/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 nursing and maintenance staff failed to ensure respiratory equipment was clean for four residents (Resident 30, 26, 42, 58) out of seven sampled residents when the oxygen concentrator (a medical device that provides supplemental oxygen to people with breathing-related conditions by pulling in ambient air, filtering out nitrogen, and delivering purified oxygen) in the resident's rooms had visible dust and debris in the vents and needed a filter change.This failure decreased the facility's potential to prevent bacteria and debris from directly entering the resident's lungs, placing them at risk for infection.Findings: 1. A review of Resident 30's admission record indicated admission to the facility on [DATE] with a diagnosis of Dementia (a progressive state of decline in mental abilities) and malignant neoplasm of the left breast (breast cancer). A review of an order listing report indicated Resident 30 had the following order dated 1/5/26 and revised on 1/6/26, Oxygen- @ [at] 2 Liters/Min [minute] via nasal canula [NC, a lightweight, flexible tubing that delivers oxygen to residents with low oxygen levels or trouble breathing] continuous [related to] medical diagnosis [of] SOB [shortness of breath] to maintain O2 [oxygen] sats [saturation, the percentage of oxygen in the blood] greater than 90% every shift for SOB. During a concurrent observation and interview with the Maintenance Supervisor (MS) and the Infection Preventionist (IP) on 3/10/26 at 3:20 p.m. in Resident 30's room, Resident 30 was lying in bed, asleep, with both prongs of the NC resting to the left of Resident 30's nostril. The MS opened the filter compartment of Resident 30's oxygen concentrator. The outside vent had dust on it and the inside compartment had large areas of dust build up. The MS confirmed the internal filter needed to be changed, and the oxygen concentrator needed to be cleaned overall. The IP confirmed the oxygen concentrator needed to be cleaned and the filter changed. The IP confirmed it could be harmful to the resident to be using a compressor (a mechanical device that converts power from an electric motor into potential energy stored in pressurized air) when the filter is so dirty. 2. A review of Resident 26's admission record indicated Resident 26 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease (COPD-a progressive lung disease that blocks airflow, making it difficult to breathe), Hypoxemia (abnormally low levels of oxygen in the blood) and history of recurrent Pneumonia (a lung infection where the air sacs fill with pus or fluid with an occurrence of two or more episodes of pneumonia within a single year, or three or more within a lifetime). A review of Resident 26's order listing report indicated Resident 26 had the following order, dated 1/5/26, Oxygen @ 2 Liters/Min [L/M] via nasal cannula continuous goal to maintain O2 sats greater than 90% every shift related to [COPD].Maintain [O2 sats] at greater than 90%. During an observation in Resident 26's room on 3/10/25 at 9:16 a.m., Resident 26 had oxygen being delivered at 2 L/M via an NC. This surveyor observed dust build-up on the outside vent of the oxygen concentrator with dust covering the outside of the machine. During a concurrent observation and interview in Resident 26's room on 3/10/26 at 3:25 p.m., the IP and MS opened the filter compartment of Resident 26's oxygen concentrator. The inside compartment had scattered areas of dust build-up. The MS and IP confirmed the internal filter needed to be (continued on next page)

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	03/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	changed, and the oxygen concentrator needed to be cleaned. 3. A review of Resident 42's admission record indicated admission to the facility on [DATE] with a diagnosis of Dependence on Supplemental Oxygen. A review of Resident 42's order listing report indicated Resident 42 had the following physician's order dated 1/5/26, Oxygen @ 2 L/M via NC continuous. for SOB. During an observation in Resident 42's room on 3/10/26 at 8: 52 a.m., Resident 42 was sitting up in bed with an NC in place in both nostrils. The oxygen concentrator was noted to have dust buildup on the outside vents. During a concurrent observation and interview in Resident 42's room on 3/10/26 at 3:20 p.m., the IP and MS opened the filter compartment of Resident 42's oxygen concentrator. The inside compartment was noted to have a layer of white dust and debris throughout. The internal filter appeared to be discolored. The MS confirmed the filter needed to be changed. The IP stated a dirty oxygen concentrator was not good for the resident receiving the oxygen therapy. The MS stated the housekeeping department should be cleaning the outside of the oxygen concentrator and the vendor of the machine had monthly visits to repair, troubleshoot, clean and change internal filters. The MS could not recall when the vendor's last visit to the facility took place. Resident 42 stated, No one has been cleaning that [oxygen concentrator]. 4. A review of Resident 58's admission record indicated admission to the facility on 9/24/25 with diagnoses of COPD and Chronic Respiratory Failure with Hypoxia (long term lung condition where the lungs cannot adequately transfer oxygen into the blood, causing persistent low oxygen levels which is treated with long term oxygen therapy). A review of Resident 58's order listing report indicated the following physician orders, dated 1/5/26, Oxygen @ 3 [L/M] via nasal cannula continuous. During an observation in Resident 58's room on 3/10/26 at 10:15 a.m., Resident 58 was sitting up in bed with an NC in place to both nostrils. The oxygen concentrator was noted to be administering oxygen at 2 L/M. The concentrator felt hot to the touch. The outside vent was noted to have a large amount of dust buildup and there was dust covering the entire machine. During a concurrent observation and interview in Resident 58's room on 3/10/26 at 3: 32 p.m., the IP and MS opened the filter compartment of Resident 58's oxygen concentrator. The MS confirmed this oxygen concentrator belonged to the facility and it would have been his responsibility to ensure facility owned equipment was operating effectively and in clean, working condition. The MS and IP confirmed that one of side filters hidden by a screwed in plate, had a thick layer of dust build up. Once the internal compartment was opened, the same thick layer of dust build-up was observed. The IP suggested the oxygen concentrator be removed from Resident 58 and replaced with a clean oxygen concentrator. This surveyor requested to see cleaning logs for all oxygen concentrators being used on the residents. During an interview in on 3/11/26 at 9:39 a.m., the MS stated his department had no cleaning logs for the facility owned oxygen concentrators. The MS provided a sheet titled Cleaning Guide which listed daily cleaning performed by the housekeeping staff;Oxygen concentrators were not found on this list. This surveyor requested to see vendor logs of monthly visits, and requested information on when the (continued on next page)

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	03/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility owned oxygen concentrator was put in place for Resident 58. During an interview in on 3/12/26 at 8:57 a.m., the IP stated the dusty oxygen concentrators posed an infection risk for the residents. She stated the dust and debris can hold bacteria, spores and other pathogens that can enter the resident's respiratory system. The IP stated this placed the residents at risk for a chronic cough, delayed healing or other respiratory diseases. During an interview in the facility hallway on 3/12/26 at 10 a.m., the Administrator (Admin) stated the two facility owned oxygen concentrators were delivered on 2/10/25 and 3/17/25. The Admin stated the MS had no record of what machine was placed for Resident 58 or when it was placed. This surveyor asked the Admin to retrieve vendor maintenance and cleaning logs for the oxygen concentrators. The Admin stated the MS was not at the facility today. During an interview in the maintenance department on 3/13/26 at 9:14 a.m., the MS stated he could not find the maintenance and cleaning logs from the vendor. The MS further stated the oxygen concentrator for Resident 58 was put in place on 3/17/25 and to his knowledge, it had remained there. A review of facility's policy titled Oxygen Concentrator Cleaning & Disinfection Policy, revised October 2025, indicated, To ensure oxygen concentrators are properly cleaned and disinfected between resident use and routinely maintained to prevent the transmission of infectious organisms and maintain safe equipment function.Routine cleaning (weekly or as needed): Nursing or designated staff shall perform routine cleaning of the oxygen concentrator.wipe the exterior surfaces.Filter maintenance: External filter.clean weekly or when visibly dirty.Internal filter.replaced according to biomedical or vendor maintenance schedule. A review of the facility owned oxygen concentrator Owner's Manual, dated 2020, indicated, more frequent cleaning and filter changes may be required if.you are operating the concentrator continuously.

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	03/13/2026

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 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 observation, interview and record review, the facility failed to ensure licensed nurses did not administer oxygen per physician's orders for two residents (Resident 67 and Resident 58) of nine sampled residents when:Resident 58 did not have the ordered amount of oxygen being delivered and,Resident 67 did not have a humidifier attached to the oxygen concentrator (a medical device that provides supplemental oxygen to people with breathing-related conditions by pulling in ambient air, filtering out nitrogen, and delivering purified oxygen)These failures had the potential to place residents at risk for inadequate oxygenation and a potential decline in respiratory status.Findings: 1. A review of Resident 58's admission record indicated Resident 58 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease (COPD-a progressive lung disease that blocks airflow, making it difficult to breathe) and Chronic Respiratory Failure with Hypoxia (a long term lung condition where lungs cannot adequately transfer oxygen into the blood, causing persistent low oxygen levels). A review of Resident 58's care plans, dated 10/7/25, indicated Resident 58 was at risk for respiratory distress (a clinical state of difficulty breathing characterized by rapid, labored or inadequate breathing, where the body struggles to get enough oxygen). In order to reach Resident 58's goal to maintain comfort and avoid respiratory complications, the staff were expected to provide oxygen therapy as MD ordered. A review of Resident 58's physician orders, dated 1/5/26, indicated Resident 58 had an order for Oxygen @ [at] 3 Liters/Min [liters per minute-measures flow rate or volume of oxygen being delivered over one minute] via Nasal Cannula [a lightweight, flexible tubing that delivers oxygen to residents with low oxygen levels or trouble breathing] continuous. During an observation in Resident 58's room on 3/10/26 at 10:15 a.m., Resident 58 was sitting up in bed with a nasal cannula in place in both nostrils. The oxygen concentrator was noted to be administering oxygen at 2 L/M. During a concurrent observation, interview, and record review in Resident 58's room on 3/11/26 at 3:43 p.m., Licensed Nurse 6 (LN 6) confirmed the Resident 58's oxygen concentrator was set at 2 L/M, despite the current physician order directing oxygen to be delivered at 3 L/M. LN 6 stated she would need to locate a Registered Nurse to adjust the oxygen level to the ordered setting. A review of Resident 58's Medication Administration Record (MAR), dated March 2026, indicated licensed nursing staff had documented administration of continuous oxygen therapy at 3Liters/Minute [3 L/M] from March 1 through March 11, 2026. A review of Resident 58's progress notes dated between 1/5/26 to 3/10/26 revealed no documentation which explained why oxygen therapy was not provided as ordered, nor documentation of any notification to the physician regarding deviation from the prescribed treatment. During an interview on 3/12/26 at 11:30 a.m., the Director of Nursing (DON) confirmed that staff were expected to follow all physician orders, including those related to oxygen administration, and acknowledged that the facility failed to ensure oxygen was provided according to the physician's order. (continued on next page)

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	03/13/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 67's admission record indicated Resident 67 was admitted to the facility on [DATE] with a diagnosis that included COPD. A review of Resident 67's order summary report indicated Resident 67 had the following orders dated 2/27/26: -Change O2 [oxygen] humidifier Discard and replace the disposable.prefilled humidifiers as needed when consumed, when bubbles are no longer visible. -Change O2 humidifier Discard and replace the disposable.prefilled humidifiers every night shift every Sun [Sunday]. -Oxygen @ 2 L/M via Nasal Cannula continuous.[related to diagnosis].COPD/ SOB [shortness of breath] Goal To Maintain O2 sats [saturation- the percentage of oxygen in the blood] between 88%-92% every shift. A review of Resident 67's care plans, dated February 2026 did not indicate a care plan was developed for Resident 67's oxygen therapy. During an observation on 3/10/26, at 10:15 a.m., Resident 67 was sitting up in bed with a nasal cannula in place in both nostrils. The oxygen concentrator was observed to be administering oxygen at 1.5 L/M there was no humidifier attached to the oxygen concentrator. During an interview on 3/11/26, at 11:30 a.m., the Infection Preventionist (IP) confirmed that Resident 67 did not have a humidifier attached to her oxygen concentrator. A review of facility policy titled Oxygen Administration, revised April 2025, indicated, .the purpose of this procedure is to provide guidelines for safe oxygen administration.Verify that there is a physician's order for this procedure.turn on the oxygen.start the flow of oxygen at [sic] ordered. A review of facility policy titled Physician Orders and Physician Notification, revised April 2025, indicated, The facility ensures that all resident care is provided in accordance with timely, complete, and authenticated physician orders.Orders shall be implemented promptly.Responsibilities.Licensed Nurses.Identify changes, notify physicians, document accurately, and implement orders.

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	03/13/2026

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility's Interdisciplinary Team (a collaborative group of health care professionals who provide comprehensive, patient-centered care) failed to initiate a comprehensive care plan regarding Resident 46's hearing impairment and ensure hearing services were provided for Resident 46 of two sampled residents .This failure decreased the facility's potential to assist residents in gaining access to necessary care regarding her hearing impairment.Findings:A review of Resident 46's admission record indicated admission to the facility on [DATE] with a diagnosis that included Hypertensive Heart (structural and functional heart damage caused by long-term high blood pressure, leading to heart failure), Chronic Kidney Disease (long-term, progressive loss of kidney function, often causing waste buildup, high blood pressure, and anemia), and a History of Falling.A review of Resident 46's admission inventory list dated 12/30/25 indicated Resident 46 had right and left hearing aids.A review of Resident 46's care plans dated 12/30/25 did not indicate a care plan was developed for Resident 46's hearing impairment.A review of Resident 46's minimum data set (MDS, an assessment tool) dated 1/12/26, indicated Resident 46 used a hearing aid or hearing appliance and had adequate ability to hear (with hearing aid or hearing appliances if normally used) and had a Brief Interview for Mental Status (BIMS, an assessment tool that helps determine an individual's memory and orientation) score of 11 (indicates moderate cognitive impairment, and represents a moderate level of difficulty with memory). During an interview on 3/10/26 at 10a.m., Resident 46 was lying in bed awake with the head of the bed elevated. Resident 46 asked this surveyor to please speak loudly because she could not hear very well. When asked if she wore hearing aids she stated Yes, but they needed to be serviced and were not working. Resident 46 stated she has not been able to have her hearing aids serviced and to make an appointment to see her ear doctor for a check-up. When asked if the facility was helping her schedule an appointment she stated, No. During an interview on 3/11/26 at 11:45 a.m., LN 4 stated Resident 46 was hard of hearing, and added you must speak slowly and loud to her. LN 4 acknowledged he was unaware Resident 46 had hearing aids and stated facility staff could arrange an appointment for her to see the audiologist (a licensed healthcare professional specializing in identifying, assessing, and managing hearing, balance, and tinnitus disorders in patients of all ages.)During an interview on 3/11/26 at 11:50 a.m., the Medical Doctor (MD) stated Resident 46's hearing had declined but that she did understand our conversations, and it did not interfere with communicating with her. The MD stated, She gets by.A review of the facility's policy and procedures titled, Care Plans, Comprehensive Person-Centered, revised March 2025, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.The .IDT, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment and no more than 21 days after admission. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.The comprehensive, person-centered care plan.describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including.services that would otherwise be provided for the above.which professional services are responsible for each element of care.includes the resident's stated goals upon admission and desired outcomes.reflects currently recognized standards of practice for problem areas and conditions .

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	03/13/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the licensed nurses failed to ensure pharmaceutical services met the needs of each resident when:The facility did not sign delivery receipts for narcotic and non-controlled medications on 3/1/26, 3/2/26, 3/6/26 to 3/8/26, and 3/10/26 for a combined total of 1,036 doses.Licensed Nurse (LN) 1 left medications at Resident 44's bedside.These failures decreased the facility's potential to ensure safe and secure medication management, increased the risk of medication loss or diversion (the illegal transfer of prescription drugs to be sold for profit or for personal abuse) and decreased the potential for medications to be safely administered among residents.Findings:1. During a concurrent interview and record review with LN 4 at the South Nurses station on 3/12/26 at 11:42 a.m., the binder containing pharmaceutical delivery receipts was examined. LN 4 confirmed there were no signatures present on the delivery receipts dated 3/1/26, 3/2/26, 3/6/26 to 3/8/26, and 3/10/26. The absence of these signatures indicated the delivery and acceptance of residents' medications had not been properly documented. LN 4 said the significance of a signed pharmaceutical delivery receipt was to prove the medication has been delivered and placed in the medication cart.During a concurrent interview and record review with the Director of Nursing (DON) in the DON's office on 3/12/26 at 12:01 p.m., the DON confirmed the pharmaceutical delivery receipts for the specified dates in March 2026 had no signatures from either the pharmacy staff nor the facility licensed staff. The DON stated the expectation was that medications received from the pharmacy were reconciled (comparing the receipt of medications against medications delivered) immediately, any errors noted, followed by a signature to indicate acceptance of medication delivery. The DON stated unsigned pharmaceutical delivery receipts placed the facility at increased risk for diversion.A review of the facility's policy titled Accepting Delivery of Medications dated 2001, indicated, All staff follow a consistent procedure in accepting medications.before signing to accept the delivery, the nurse reconciles the medications in the package with the delivery ticket/order receipt.a nurse signs the delivery ticket, indicating review and acceptance of the delivery, and keeps a copy of the delivery ticket.2.A review of Resident 44's admission record indicated admission to the facility on [DATE] with diagnoses including Spondylolisthesis (a condition in the spine where one of your backbones slip forward out of its normal alignment onto the bone below) and disorders of bone density.A review of Resident 44's Minimum Data Set (MDS-a federally mandated assessment tool) indicated a Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgment status of the resident) score of 11 of 15 which indicated moderate cognitive (the process of obtaining knowledge and understanding through the use of thought, experience, and senses) impairment.During an observation, upon entry to Resident 44's room on 3/10/26 at 9:09 a.m., Resident 44 attempted to swallow a pill and spit it out. This surveyor observed two additional pills left on Resident 44's bedside table. Resident 44 attempted to take the same pill she spit out two more times while this surveyor was in her room. Resident 44 spit the pill out for a third time and left it on the bedside table with the 2 other pills. During a concurrent interview and record review at the North Med Cart on 3/10/26 at 9:21 a.m., LN 1 confirmed leaving medications at the bedside could be a safety issue; however, he felt Resident 44 was capable of taking her medications without supervision. A review of Resident 44's physician orders was conducted with LN 1, who confirmed Resident 44 did not have orders which indicated Resident 44 was safe to self-administer her medications. LN 1 further stated the pill Resident 44 spit out was acetaminophen (over the counter medication used to treat pain). LN 1 stated the acetaminophen was requested by Resident 44 to treat pain she had rated as a 7 on a 1 to10 pain scale (10 being the worst pain). LN 1 stated the other two pills left on the bedside tray were calcium (used to strengthen bones and treat osteoporosis [a bone condition characterized by bones have decreased density and structural (continued on next page)

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	03/13/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	deterioration]), and Vitamin B complex.During an interview on 3/12/26 at 11:30 a.m., the DON confirmed medications left at any resident's bedside without physician approval was a safety concern.A review of facility policy titled Administering Medications, revised April 2025, indicated, Medications are administered in a safe.manner. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.

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	03/13/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the licensed nurses failed to ensure residents were free from significant medication errors for three residents (Resident 6, 32, and 8) of 10 sampled residents when:1. Residents 6 and 32 were not administered insulin pen injections as per manufacturer's instructions and;2. Resident 8 was not administered rifaximin (a medication used to kill bacteria that produces ammonia in the intestines and prevents toxins from reaching the brain and causing confusion or severe personality changes) for 36 doses.These failures placed the residents at risk for avoidable adverse clinical outcomes including uncontrolled blood glucose levels and exacerbation of liver disease.Findings:1. During a concurrent interview and medication pass observation on [DATE] at 8:17 a.m., Licensed Nurse 2 (LN 2) administered 20 units of glargine (long-acting insulin which provides steady 24-hr blood sugar control) via an insulin pen to Resident 32's right lower abdomen. LN 2 injected the insulin and removed the pen immediately. LN 2 did not maintain the needle in place as instructed by the manufacturer. LN 2 stated he was nervous and thought he had held the pen to Resident 32's skin.During a concurrent interview and medication pass observation on [DATE] at 4:13 p.m., LN 5 administered 4 units of lispro (fast acting insulin with a rapid onset and short duration) into Resident 6's left abdomen. LN 5 did not maintain the needle in place for the required duration, withdrawing the pen 5seconds after injection. LN 5 stated she was aware she pulled the pen away from Resident 6's skin slightly earlier than required.During an interview on [DATE] at 11:30 a.m., the DON acknowledged insulin pens required a certain duration held against the skin to ensure full insulin dose had been given. The DON stated an in-service was provided by the Pharmacy Consultant (PhC) in June of 2025 which covered this amongst other topics. This was not a mandatory in-service, but strongly recommended.During a phone interview on [DATE] at 1:51 p.m., the PhC stated he reviewed insulin pen administration during his in-service. The PhC stated he informed the licensed staff the insulin pens needed to stay intact on the skin for 6-10 seconds, depending on the type of insulin given; longer acting insulins require at least 10 seconds of hold time, shorter acting insulins can be removed after 6 seconds of hold time. The PhC stated removing the pen too early can result in underdosing the resident, possibly causing a spike in blood sugar levels.2. A review of Resident 8's admission record indicated admission to the facility on [DATE] with diagnoses of Alcoholic Cirrhosis (the final, most severe stage of alcohol associated liver disease characterized by extensive, irreversible scarring of the liver due to years of excessive drinking) andPortal Hypertension (elevated blood pressure within the portal system, which carries blood from the digestive system to the liver; usually caused by the scarring of the liver, which blocks blood flow, resulting in increased pressure).A review of Resident 8's physician orders, dated [DATE], indicated Resident 8 had an order to receive 550 milligrams (mg-a unit of measure) of rifaximin by mouth two times a day for prophylaxis (a treatment used to prevent the onset or spread of a disease) for hepatic encephalopathy (a reversible, serious decline in brain function due to severe liver disease).A review of the Medication Administration Record (MAR) key indicated the number 9 signified medication not available. A review of Resident 8's MAR dated February 2026 indicated 15 entries marked with a 9 for the ordered medication rifaximin, indicating the medication was not available and therefore not administered. A review of the MAR dated [DATE] presented an additional 14 missed doses of rifaximin, also documented with the 9 code. Seven doses were checked off as administered on [DATE],4,7,8,9 in between several days of medication not being administered. During an interview in Resident 8's room on [DATE]at 10:24 a.m., Resident 8 stated the facility stopped giving him his liver medication about one month ago because it was too expensive. He stated the facility is also giving him other medication to treat his liver disease, but that it is only part of his full treatment. Resident 8 stated he was worried his ammonia level was rising and that he was already starting to feel weird and falls asleep at abnormal times during the day. During an interview at the south nursing station on [DATE] at 8:04 a.m., LN 4 stated physician (MD) notification would be (continued on next page)

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	03/13/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placed in the progress notes.A review of Resident 8's progress notes did not indicate any notification to either Resident 8's MD or the Director of Nursing (DON) regarding the critical missing medication.During an interview in the DON's office on [DATE] at 8:18 a.m., the DON stated she became aware of Resident 8 not receiving his rifaximin treatment at the beginning of the month when she received an authorization from the pharmacy for the rifaximin. The DON stated she called the pharmacy to escalate the urgency and notified the MD. The DON stated the physician increased Resident 8's lactulose (medication used to reduce blood ammonia levels in liver disease) on [DATE]. The DON further stated she understood the critical nature of obtaining this medication and has reached out to the pharmacy on at least four occasions. She was told they needed authorization to proceed with ordering the medication. She stated she was working with the MD and the pharmacy to expedite the process. The DON confirmed there were no nursing progress notes to indicate MD notification. She further confirmed the seven doses documented as given on Resident 8's MAR was documented in error. The rifaximin has not been issued from the pharmacy since [DATE]. The DON confirmed the total missed doses of rifaximin was 36. The DON also confirmed the nursing staff should have notified the MD and herself about the missing rifaximin.During an interview in room [ROOM NUMBER] on [DATE] at 10:21 a.m., the MD stated, If [Resident 8] does not get his rifaximin, he will die. He [Resident 8] is on the maximum dose of lactulose at 45 milliliters four times daily. There is nothing more we can do to stop the decline. We need the medication [rifaximin].During a phone interview on [DATE] at 1:51 p.m., the PhC stated he became aware of the situation with Resident 8 earlier that morning while speaking with the DON. He stated Resident 8's prior authorization for the medication had expired, and the physician needed to justify the prescription. When that task was completed, the pharmacy would submit to Resident 8's insurance plan for approval. The whole process should take 2-3 days.A review of facility policy titled Adverse Consequences and Medication Errors, revised 2/2025, indicated the facility, monitors medication usage in order to prevent and detect medication related problems.A medication error is defined as.the administration of drugs which is not in accordance with physicians orders.or accepted professional standards.examples of medication errors include: omission- a drug is ordered but not administered.failure to follow.accepted professional standards.promptly notify the provider [physician] of any significant error.