STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055510	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redding Post Acute	1836 Gold Street Redding, CA 96001

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 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** 41715 Based on interview and record review, the facility failed to ensure that one of six residents who were sampled for quality of care (Resident 1), received care that was in accordance with professional standards and consistent with Resident 1's preferences and goals and at the level of assistance he needed. Resident 1 was admitted for Comfort Care (end of life care) on the afternoon of 9/14/24, and requested not to be put into a brief (adult diaper). During the night shift on 9/14/24, Certified Nursing Assistant (CNA) D had left Resident 1 in a soiled night gown, soiled brief, wet sheets, and the television (TV) in his room blaring and had not assisted Resident 1 in eating his supper. Resident 1 was found on 9/15/24 around 6:45 am, by his Family Member (FM) A and CNA C, in a soiled and soaking wet brief and hospital gown with dried brown rings on his bed sheets and the TV blaring. These failures resulted in Resident 1 having a horrible experience and lack of sleep and he left the facility that morning and returned to the hospital. These failures had the potential for residents to experience an undignified existence, discomfort, skin breakdown, nutritional declines, loss of sleep and inability to attain or maintain their highest practicable level of physical and emotional well-being. Findings: Resident 1 was admitted to the facility on [DATE] around 4 pm, from the hospital with conditions ranging from thrombocytopenia (low platelets, inability of the blood to clot), an infected pacemaker (an implanted device that regulates the heart beat), and was terminally ill (dying). Resident 1 was admitted to receive comfort care (support of a resident ' s emotional and physical needs while at the end of life, focusing on comfort rather than treatment). Resident 1 requested to return to the hospital on 9/15/24, after about a 12 hour stay at the facility. A review of the, National Institutes of Health Information, Providing Care and Comfort at the End of Life, (undated), indicated, physical comfort (e.g. soft lighting, soft sounds) are a critical part of comfort care. A review of the facility ' s policy titled, Resident Rights dated 12/2021 indicated that various rights are guaranteed to all residents by federal and state law including, to be treated with respect, kindness, and dignity and to be free from .neglect. (continued on next page)

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	Resident 1's Progress Notes were reviewed. On 9/14/24, Licensed Vocational Nurse (LVN) B documented that Resident 1 was admitted around 4 pm, for end of life comfort care related to multiple comorbidities [many illnesses]. Further review of that record indicated under continence (ability to hold/control stool and urine) that Resident 1 had mixed continence of bladder (occasions where a loss of control may happen). Resident 1's Progress Notes were further reviewed. On 9/15/24 at 9:15 am, LVN B documented, Family had concerns about resident care and thought comfort care was questionable, resident alert and able to express himself, family arrived early this am and was told by resident that he had not received any care all night, and roommate yelled out most of the night, TV on and loud volume all night. Review of the record titled, Admission Assessment for Resident 1 dated 9/14/24 indicated Resident 1 was aware of person, place, and time and was continent (full control) of his bowel and bladder and had an indwelling urinary catheter (sometimes called a Foley catheter, a tube inserted into the urethra to drain the bladder). Review of a statement written and signed by CNA C, dated 9/15/24, was provided by the Administrator (ADMIN) and indicated, I was checking rooms at 0645 when I noticed that room [ROOM NUMBER]A resident's [FM A] was upset at the current state of her father. Upon entering the room, I noticed 25A was soaked as well as dried ooze over his entire bed and gown. There wasn't much water. 25A told me that no CNA came in all night and he has been sitting in his filth for more than 8 hours. The [FM A] was extremely upset, I changed the bedsheets, gave the client more water, took off the diaper and left it off, and let the nurse know exactly what had happened. Review of a document signed by CNA D was provided by the facility ADMIN titled, Employee Warning/Discipline/Coaching Memo dated 9/16/24. The record indicated that Resident 1 was left heavily soiled, that CNA D ' s last interaction with the resident was at 3 am, while his shift was not over until 7 am. The record indicated that corrective action was taken regarding performing two-hour rounding (checking) on rooms, making sure walking rounds (where the on-coming and off-going CNAs inspect the residents together), at change of shift and coaching in incontinence care. In an interview on 9/18/24 at 4:46 pm, FM A stated that Resident 1 was placed in a diaper after telling the night nurse he was not incontinent and didn ' t want to wear a diaper. FM A stated that when she came into the facility early in the morning of 9/15/24, Resident 1 was in a messy diaper and the bed was saturated. FM A stated that Resident 1 was not incontinent. FM A further stated that Resident 1 appeared frightened when she arrived early morning on 9/15/24. His TV was so loud that I had to put my mouth to his ear and yell. He was telling me that he complained at night for them to turn the TV down, but it was just as loud at 7 am as it was the night before. He was a mess in a room with a blasting television; he had asked the night staff to turn it down and they responded to him that his roommate liked it that way. I asked [Resident 1], Do you want me to get you out of here? He said, Ok, get me out of here. FM A stated, Based on what I saw, there was a total lack of compassion. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/19/24 at 4:45 pm, Resident 1 was interviewed by telephone in his home. Resident 1 stated that being at home and being cared for by his daughters, was precisely the situation he had tried to avoid by being admitted to the facility and that his daughters were now caring for him as he was actively dying. The hospital sent me to the facility so I could get ready to pass on. I didn't want my daughters to take care of me, so I went to [the facility]. All I wanted was to be comfortable and rest, but it was a horrible experience. The television was on all night long and the person next to me was screaming. I told the CNA taking care of me that I was uncomfortable, that the TV was too loud, and he told me my roommate liked it that way and did nothing about it. I asked if they had any earplugs, but he never brought them. Resident 1 also stated that he was placed in a diaper after stating to staff that he was not incontinent and had requested a bedpan, I had never had to be in a diaper before. I just figured this is what they do. I'm [AGE] years old and dying, I assumed that at least they'd give me a bedpan if I asked for one. Resident 1 stated that during that night shift he was unable to eat or drink and received no assistance, I didn't get to eat my meal. I was slumped down in the bed and couldn't even see or reach the food. The aide just plopped it down on the table and it stayed there all night, there was no way I could get to it. It was a terrible night. I asked for water and never got it. I felt like I was just 'somebody in a home,' here today and gone tomorrow. In an interview on 9/23/24 at 11:50 am, LVN A stated, Our protocol for admitted residents is to monitor their bowel and bladder habits from the moment they get here to determine continent versus incontinent and their needs. Nutrition is the same, it is the facility's responsibility to observe how a resident is eating their food from the first meal they get. It's obvious when you go into a room that the patient hasn't touched their food, it's questionable why they aren't eating. We should be taking note of that from their first meal here. LVN A stated that a resident's request should never be ignored. In an interview on 9/23/24 at 12:00 pm, Assistant Director of Nursing (ADON) A stated that she was aware of the situation with Resident 1 and heard about him asking for earplugs and and a request for a bed pan, instead of diapers. ADON A stated, They should have given him a bedpan, it's a basic nursing intervention for his dignity. Regarding ear plugs, ADON A stated, We have ear plugs and offer them to residents when requested. I know earplugs are available. In a concurrent record review of Resident 1 ' s hospital discharge summary that was provided to the facility on [DATE], ADON A confirmed Resident 1 was continent of bowel and that he could not walk to the restroom, not ambulatory. In an interview on 9/15/24 at 12:15 pm, LVN B stated that she was aware of Resident 1 ' s concerns. The CNA who was assigned that morning saw that he was very soiled, laying in head to toe urine. He had a wound on his right side that had covered the sheet in dried pus. I know this happened that night [9/14/24]. Also, when urine sits for more than a few hours on a sheet, it makes a brown recognizable 'ring.' I could tell the urine had been there all night. The night shift CNA was CNA D. LVN B confirmed that Resident 1 was alert and oriented and could make his needs clearly known. LVN B indicated that CNAs work according to a scheduled routine rounding every two hours, concluded by rounds on the night shift about 4:30 am, preparing for the next shift. LVN B stated that CNA D, could not have done those rounds or he would have noticed the sheets. Regarding the room noise, LVN B stated, We usually have a rule, 10 pm, the television needs to be turned down. This patient hadn't been with us that long and his roommate tends to yell out at night, which was another problem. I was not aware he requested a bedpan. He came to us incontinent per his records, it was for him, not for the convenience of staff. He appeared able to feed himself, he was able to hold a cup. He wasn't with us long enough to do a full assessment or lengthy evaluation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/23/24 at 12:45 pm, CNA C confirmed that he came in to find Resident 1, filthy and saturated with urine. CNA C stated that Resident 1's bed had not been changed, and that bed pans were always available to residents if they wanted one, we have three types of them. CNA C further stated, When we came in that morning, the room lights were all on, the TV was loud in the room, to the point where the resident across the hall closed their door. I ended up finding the remote and turning it down. [Resident 1] had a wound on his right side that had pus all over the sheet and the bed was saturated. CNA C confirmed that the night shift CNA was CNA D. CNA C stated, The family was unhappy and there was nothing I could do to console them, and I didn't blame them. In an interview on 9/23/24 at 12:55 pm, Director of Staff Development (DSD, nurse who trains CNAs) E stated, I spoke to [CNA C] after the situation. He came on shift and stated that he had been doing room rounds and went in to see [Resident 1] whose [FM A] was upset. [CNA C] had to change the bed, it was heavily soiled. I had to contact CNA D to educate him about room rounds, thorough documentation, and taking residents to the restroom or changing them every two hours. DSD E stated, regarding Resident 1's supper meal tray, When a resident first arrives, we have to assist at the bedside to assess if they're eating their meals. If he hadn't eaten his food, it would have been determined immediately and we should have intervened by either offering an alternative or determining why he wasn't eating. Regarding ear plugs, DSD E stated, We are pretty quick to respond, we have headphones and earplugs for residents. In an interview on 9/26/23 at 5 pm, with LVN F, she confirmed that she assumed the care of Resident 1 on 9/14/24 at 10 pm. LVN F indicated that she had taken over for another nurse who had completed the nursing assessments and did the initial rounds. LVN F stated, It was a busy night, 3 admits lots of comfort care residents, and only 2 aides; [CNA B] and a CNA from a registry [temporary staffing agency]. LVN F indicated that CNA B was in Resident 1's room a lot because the roommate needed a lot of care and there was a lot going on, but could not confirm that she witnessed CNA B actually giving care to Resident 1. LVN F stated, I went in to listen to [Resident 1's] lungs and give him pain medication if he needed it. His daughter gave me information about him being hard of hearing, requiring feeding assistance with meals because he couldn't eat on his own. LVN F was not able to confirm whether or not Resident 1 had eaten supper. LVN F confirmed that Resident 1 had an indwelling urinary catheter, and I don't recall what he was wearing, usually if they have a foley it's their own clothes and chux [pad for the bed]. He was alert and oriented and able to use a bedpan, but I don't know if [Resident 1] had a bedpan, because I didn't see what supplies were taken into the room that night. LVN F indicated that there were two TVs in Resident 1's room, she did not recall the TV being loud but stated that resident's roommate was very loud and yelling out when care was provided to him. LVN F indicated that she was unaware of Resident 1's request for earplugs or for a bedpan and that Resident 1 never complained to her about anything. LVN F indicated that she had not seen what Resident 1's bedsheets looked like. LVN F indicated that she left the facility at 7 am the next morning, on 9/15/24, and no staff had approached her about problems with Resident 1's care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/26/24 at 6 pm, CNA D stated, I was surprised about it. I told the [ADMIN] the night I was on duty that I was in that room a lot when I came into work, I had to remove all the trays and went to him [Resident 1] he refused feeding and asked me to leave the tray. Asked if he wanted something else, grilled cheese, he said to leave the tray there, would have given to him. Asked him several times during night he said leave it there. He called me at midnight BM [bowel movement] and I cleaned him, nothing else happened, I checked him, he called me by name and I said thank you. I attended to him every two hours. I was so busy that night. Second bed TV on but wasn't too loud, he [Resident 1] didn't complain. By the time I got my last rounds at 5 am, got to him, discovered he had a little BM, made me change his brief again, turn him on his strong side, not leaking, no complaint. No pus. First thing I would have done is to report to nurse. He was friendly to me. Of course I supplied fresh water. Saw him drinking, no issues, if he had complained about anything I would have done it.