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	02/20/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to maintain food safety requirements regarding a clean and sanitary kitchen environment for food preparation for all residents who consumed food prepared by the kitchen when:1.The perimeter of the kitchen's walls at the height of the counters and below including pipes, drains, electrical coverings, and flooring were spackled with a filth buildup of food particles and adhered grime.2.The paint was chipped, peeling and worn out on walls, sink, and around flooring.3.The exterior of the stove/oven was unclean with cooked on grime.4.Rolling dollies with buckets of kitchen supplies were dirty with black filth.5.The walk-in refrigerator's flooring was found to be buckled and uneven with a vein of rust expanding down the un-joined seam of the flooring, and when cleaned the rust material puddled from under and between the seam spreading on the flooring.These failures had the potential to incite harmful growth of unhealthy microorganisms resulting in food borne illness amongst the residents that consume products produced from the kitchen which could lead to sickness and disease.During a review of the facility's policy titled, General Cleaning of Food & Nutrition Services Department, dated 2023, indicated, Floors.must be.maintained in good condition. Walls and ceilings must be washed thoroughly.Heavily soiled surfaces must be cleaned.as necessary.During a review of the facility's policy titled, Sanitation, dated 2023, indicated, All .equipment shall be kept clean, maintained in good repair .During an observation of the kitchen on 2/17/26 at 11:00 am, the perimeter walls in the kitchen were observed; multiple areas on the walls approximately the height of the counters, and under the counters to and including the floor, as well as pipes and electrical coverings were spackled with filth buildup of food particles and adhered grime, paint chipped, peeling and worn out on walls, sink, and around flooring, the exterior sides of the stove/ oven was dirty displaying cooked on grime, rolling dollies with buckets of kitchen supplies were dirty with black filth, and the flooring in the walk-in refrigerator was buckled and uneven with the seam down the middle open and unjoined which revealed a vein of rust that puddled along the floor with the cleaning process.During a concurrent observation and interview on 2/17/26 at 11:30 am, with the Food and Nutrition Manager (FNM), in the kitchen, FNM confirms the kitchen's perimeter walls, pipes and drains, electrical coverings, flooring, rolling dollies, and exterior of the stove was dirty, paint was chipped, peeling and worn out on walls, sink, and around flooring, and the flooring in the walk-in refrigerator was buckled, uneven, and has a vein of rust running down the mid-seam that oozes out and puddles when cleaned.During an interview on 2/18/26 at 3:30 pm, with the Registered Dietician (RD), in the Director of Nursing's (DON) office. The RD confirmed the kitchen was dirty and she had written reports about its lack of general cleanliness and sanitation.

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review the facility failed to maintain a safe environment for all residents who use the shower room when a spray bottle of bleach cleaner solution was observed in shower rooms one and two on wing three within unlocked cabinets above the toilets amongst toiletry essentials.This failure had the potential to result in physical injury and negatively impact the overall health for residents utilizing the common space.During a review of the facility's policy and procedure titled, Homelike Environment, dated February 2021, indicated, Residents are provided with a safe.environment.During a review of the facility's policy and procedure titled, Safety and Supervision of Residents, dated Revised July 2017, indicated, Resident safety.and assistance to prevent accidents are facility wide priorities.During an observation on 2/17/26 at 2:00 pm, on wing three, shower rooms one and two were observed to have spray bottles of bleach in unlocked cabinets above the toilet, mirroring one from the other. No lock was visually present or available.During a concurrent observation and interview on 2/17/26 at 2:05 pm, with Assistance Director of Nursing (ADON), in shower room two on wing three, the unlocked cabinet is observed with the spray bleach bottle present, with the additional observation of a photo provided by the surveyor of shower room one on wing three of the unlocked cabinet with the spray bleach bottle present. ADON stated shower room one is used as a shower/tub for residents while shower room two is used as a storage room for equipment by staff. Only shower room one affects the residents as a safety concern, but both rooms are set up in the exact same manner, so that appears to be the normal setup. We usually do lock the cabinets, but neither was locked now, and no lock is visually present.During a concurrent observation and interview on 2/19/26 at 09:00 am, with Director of Nursing (DON), in DON's office, DON confirms the cabinet should have a lock on the door, when there is a chemical such as bleach stored, for resident safety.During an interview on 2/19/26 at 10:30 am, with Administrator (Adm), in Adm office, Adm stated the spray bottle of bleach should be in a locked cabinet.During an interview on 2/19/26 at 2:30 pm, with Housekeeping/Laundry Supervisor (HLS), in hall outside of HLS office, HLS stated the spray bleach is used by Certified Nursing Assistants (CNA) and nursing staff. Housekeeping keeps it in the cupboards in the shower rooms for their cleaning use. HLS confirms the spray bottle of bleach should be in a locked cabinet.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of six residents sampled (Resident 36), right to a dignified existence was protected when her eyeglasses were not clean.This failure could have resulted in a decrease in Resident 36's vision and emotional well-being.Findings:Review of a facility policy titled, Resident Rights revised October 2025, indicated, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence.Review of Resident 36's medical record indicated that she was admitted to the facility on [DATE] with diagnoses including muscle weakness, and difficulty walking.Review of Resident 36's Minimum Data Set (MDS is a federally mandated assessment tool that measures the health status in nursing home residents) section B (part of MDS pertaining to vision) dated 1/8/26 indicated that Resident 36 wore glasses. Review of Resident 36's MDS Brief Interview for Mental Status (BIMS -an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) indicated a score of 10 out of 15 indicating moderate cognitive impairment.During a concurrent observation and interview on 2/17/26 at 11:33 am, with Resident 36, Resident 36's eyeglasses were covered in smears. Resident 36 indicated that she had told staff that her eyeglasses needed to be cleaned, but no one cleaned them and that it made it hard for her to see.During an interview on 2/18/26 at 4:13 pm, with the Director of Nursing (DON), the DON indicated that her expectation is that staff clean residents' eyeglasses daily.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the care plan was revised for one of 18 sampled residents (Resident 6) when the care plan did not include the use of TED hose (tight socks that prevent swelling in the legs).This failure had the potential to cause severe leg swelling, delayed healing and an increased risk of blood clots, which could place this resident at risk for negative clinical outcomes.During a review of the facility's policy and procedure (P&P) titled, Goals and Objectives, Care Plans, dated April 2009, indicated, goals and objectives are reviewed and/or revised: when the resident has been readmitted to the facility from a hospital or rehabilitation stay.During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated March 2022, indicated, the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including which professional services are responsible for each element of care.Resident 6 was admitted originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnoses that included pulmonary edema (buildup of excess fluid in the lungs), irregular heart rate, and muscle weakness.A review of Resident 6's Minimum Data Set (MDS, a standardized resident assessment), dated 2/17/26, indicated that Resident 6 was cognitively intact (able to think and reason).During a concurrent observation and interview on 2/17/26 at 10:30 am, with Resident 6 in her room, Resident 6 said, I am supposed to have TED hose on when I get out of bed every morning.During an interview on 2/17/26 at 11:16 am, with Certified Nurse Assistant (CNA) 1, CNA 1 said, I have been working with [Resident 6] for two months and didn't know she was supposed to get TED hose on in the mornings.During a concurrent interview and record review on 2/17/26 at 11:47 am, with Licensed Nurse (LN) 1, Resident 6's, Medication Administration Record (MAR), dated February 2026 was reviewed. The MAR indicated on 2/17/26 for the 9:00 am administration time, TED hose were applied to Resident 6's legs by CNA 1. LN 1 confirmed he charted the TED hose were on Resident 6 when they were not. During a concurrent observation and interview on 2/18/26 at 9:15 am, with Resident 6 in her room, Resident 6 said, They did not put my TED hose on this morning when I got up.During a concurrent interview and record review on 2/18/26 at 9:40 am, with LN 2, Resident 6's MAR was reviewed. The MAR indicated, LN 2 had charted that Resident 6 had TED hose on when she did not. LN 2 said, There was a CNA in the room getting her dressed and I assumed the CNA put them on. I did not see them on [Resident 6].During a concurrent interview and record review on 2/18/26 at 4:00 pm, with Director of Nursing (DON), Resident 6's MAR dated February 2026, was reviewed. The MAR indicated that LN's 1 and 2 both documented that CNA's had applied the TED hose on Resident 6. DON confirmed the TED hose were not applied.During a concurrent interview and record review on 2/18/26 at 4:11 p.m. with DON, Resident 6's Care plan dated 11/17/26 was reviewed, DON confirmed the application of TED hose had been resolved on the previous Care Plan and they did not revise the current Care Plan to include the application of the TED hose by the CNA.During a concurrent interview and record review on 2/18/26 at 4:13 pm, with DON, Resident 6's physician orders dated 2/18/26, were reviewed. DON confirmed there was an order for the CNA to place TED hose on Resident 6 in the morning and take them off in the evening. During a review of Resident 6's, Physician Order (PO), dated 3/6/24 and 2/8/26, the PO indicated, Ensure CNA has applied the below the knee TED hose daily - On in am and off in pm.During a review of Resident 6's MAR, dated February 2026, the MAR indicated, Resident 6 had pitting edema (swelling where pressing the skin creates an indication about 3-4 millimeters deep that takes up to 15 seconds to disappear) in her legs for 11 out of 17 days.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the safe storage of medications for two of five residents sampled (Resident 64 and Resident 85) when:1. Resident 64's medications from home were stored in paper bags in a cabinet in the medication room (a locked room in a healthcare facility used to store, organize, and prepare medications).2. Resident 85's medication was stored loose in a medication cup (a small, disposable cup used for measuring and administering medications) in the medication cart (a wheeled cart used in healthcare to store, medications, and supplies).These failures could have resulted in lost medications or medication errors for Resident 64 and Resident 85.Findings:1.Review of a facility policy titled, Medications Brought to the Facility by the Resident/Family revised April 2007, indicated The facility shall ordinarily not permit residents and families to bring medications into the facility.Review of Resident 64's medical record indicated that she was admitted to the facility on [DATE] with diagnoses which included lower leg fracture (broken bone) and diabetes (high blood sugar).Review of Resident 64's Minimum Data Set (MDS is a federally mandated assessment tool that measures the health status in nursing home residents) indicated that Resident 64 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 out 15 indicating she had good decision making ability.During a concurrent observation and interview on 2/18/26 at 12:20 pm, with Licensed Nurse (LN) 3, in the medication room, stapled store pharmacy bags were observed on the top, right hand side of a locked cabinet. LN 3 indicated that the stapled store pharmacy bags had Resident 64's name on them. LN 3 indicated that the facility did not usually store outside medications inside a store's pharmacy bag or inside a cabinet in the medication room and that he did not know how it got there.During an interview on 2/18/26 at 1:38 pm, with the Director of Nursing (DON), the DON indicated that when a family member brings in medication from home the facility asks them to take the medications back home. The DON indicated that she did not know why Resident 64's medications were stored in store pharmacy bags in a cabinet inside the medication room and they should not be stored there.2. Review of a facility policy titled, Storage of Medications revised November 2020 indicated, 2. Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received.Review of Resident 85's medical record indicated that she was admitted to the facility on [DATE] with diagnoses which included depression and high blood pressure.Review of Resident 85's BIMS score of 13 out 15 indicating she had good decision making ability.During a concurrent observation and interview on 2/18/26 at 12:30 pm, of medication cart 1 with LN 2, upon opening the top righthand drawer of the medication cart there was a medication cup with pills inside of it sitting in the drawer. LN 2 indicated that the medications were for Resident 85 who would not take them earlier in the day.During an interview on 2/18/26 at 1:45 pm, with the DON indicated that no medications should be kept in a medication cup inside the medication cart and that when a resident will not take medications, the medications should be disposed of.