STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055516	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chico Terrace Care Center	188 Cohasset Lane Chico, CA 95926

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32797 Based on observation, interview, and record review the facility failed to identify and act upon a change in condition by notifying the physican of post fall pain for one out of six sampled residents (Resident 4). This resulted in delay of treatment which caused unnecessary pain and suffering. Findings A review of Resident 4 ' s admission record indicated he was admitted to the facility on [DATE], with diagnoses which included dysphagia and aphasia following a cerebral infarction (difficulty swallowing and talking following a stroke), muscle weakness, frequent falls at home and dementia. A review of Residents 4 ' s admission notes on 6/29/24 at 1:24 pm, by a Licensed Nurse (LN) indicated resident had no pain on admission. A review of Resident 4 ' s nursing progress note dated 7/1/24 at 5:06 am, indicated Resident 4 had an unwitnessed fall at 4:45 am on 7/1/24. Resident 4 was found on the floor with wet brief twisted around his feet. LN documented Resident 4 had a new injury of skin tear between left thumb and fingers, and new pain with movement. A review of the Medication Administration Record dated 7/1/24 at 8:33 am, Resident 4 was assessed for 3 out of 10 (mild pain). On 7/1/24 at 8:05 pm, he was assessed for 4 out of 10 (moderate pain) and received Acetaminophen 2 tabs. A review of a nursing progress note dated 7/1/24 at 1:54 pm, LN documented the physical therapist reported Resident 4 yelling out and guarded pain to right hip with movement. New order for x-ray to right hip. A review of 72-hour admission note on 7/2/24 at 12:26 am, LN documented Resident 4 alert, oriented to self only, unable to make needs known. Resident 4 calls out frequently during care. Resident 4 at 4:45 am, yells when turned. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a nursing progress note dated 7/2/24 12:29 am, LN documented that Resident 1 was yelling and guarding (protecting) when turned or when right lower extremity was moved. Resident 4 continued to yell out during care, calling out to staff repeatedly but unable to state what he needs. A review of Resident 4 ' s nursing progress note dated 7/2/24 at 8:29 am, indicated Resident 4 yelling and guarding when turned or right lower extremity moved. Resident 4 continued to yell out during care, calling out to staff repeatedly but unable to state needs. There was no physician notification found in the record. A review of alert note dated 7/2/24 at 10:10 am, 24 hours later an x-ray was done and indicated possible fracture to right hip, physician notified, verbal order given to send Resident 4 out to acute care hospital. Emergency medical services (transport) called at 10:20 am and Resident 4 taken to hospital for evaluation. During an interview on 11/20/24 at 11:30 am, Licenses Nurse (LN A) stated she remembered Resident 4 on admission to be very confused unable to state pain level and hollering out often. LVN A stated this can be a sign of pain. During an interview on 12/18/24 at 10:10 am, Director of Nursing (DON) stated that typically when x-rays are ordered they are done and they get the results quickly, within a few hours, and that it was not uncommon for the technician to call with abnormal results. DON confirmed that Resident 4 ' s x-ray was not timely and this delayed physician notification of the results to determine if he needed to be evaluated at the hospital. DON stated the physician should have been notified of Resident 4 ' s post fall pain. Based on observation, interview, and record review the facility failed to identify and act upon a change in condition by notifying the physican of post fall pain for one out of six sampled residents (Resident 4). This resulted in delay of treatment which caused unnecessary pain and suffering. Findings A review of Resident 4's admission record indicated he was admitted to the facility on [DATE], with diagnoses which included dysphagia and aphasia following a cerebral infarction (difficulty swallowing and talking following a stroke), muscle weakness, frequent falls at home and dementia. A review of Residents 4's admission notes on 6/29/24 at 1:24 pm, by a Licensed Nurse (LN) indicated resident had no pain on admission. A review of Resident 4's nursing progress note dated 7/1/24 at 5:06 am, indicated Resident 4 had an unwitnessed fall at 4:45 am on 7/1/24. Resident 4 was found on the floor with wet brief twisted around his feet. LN documented Resident 4 had a new injury of skin tear between left thumb and fingers, and new pain with movement. A review of the Medication Administration Record dated 7/1/24 at 8:33 am, Resident 4 was assessed for 3 out of 10 (mild pain). On 7/1/24 at 8:05 pm, he was assessed for 4 out of 10 (moderate pain) and received Acetaminophen 2 tabs. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a nursing progress note dated 7/1/24 at 1:54 pm, LN documented the physical therapist reported Resident 4 yelling out and guarded pain to right hip with movement. New order for x-ray to right hip. A review of 72-hour admission note on 7/2/24 at 12:26 am, LN documented Resident 4 alert, oriented to self only, unable to make needs known. Resident 4 calls out frequently during care. Resident 4 at 4:45 am, yells when turned. A review of a nursing progress note dated 7/2/24 12:29 am, LN documented that Resident 1 was yelling and guarding (protecting) when turned or when right lower extremity was moved. Resident 4 continued to yell out during care, calling out to staff repeatedly but unable to state what he needs. A review of Resident 4's nursing progress note dated 7/2/24 at 8:29 am, indicated Resident 4 yelling and guarding when turned or right lower extremity moved. Resident 4 continued to yell out during care, calling out to staff repeatedly but unable to state needs. There was no physician notification found in the record. A review of alert note dated 7/2/24 at 10:10 am, 24 hours later an x-ray was done and indicated possible fracture to right hip, physician notified, verbal order given to send Resident 4 out to acute care hospital. Emergency medical services (transport) called at 10:20 am and Resident 4 taken to hospital for evaluation. During an interview on 11/20/24 at 11:30 am, Licenses Nurse (LN A) stated she remembered Resident 4 on admission to be very confused unable to state pain level and hollering out often. LVN A stated this can be a sign of pain. During an interview on 12/18/24 at 10:10 am, Director of Nursing (DON) stated that typically when x-rays are ordered they are done and they get the results quickly, within a few hours, and that it was not uncommon for the technician to call with abnormal results. DON confirmed that Resident 4's x-ray was not timely and this delayed physician notification of the results to determine if he needed to be evaluated at the hospital. DON stated the physician should have been notified of Resident 4's post fall pain.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32797 Based on interview and record review the facility failed to develop a Person-Centered baseline care plan within 48 hours of a resident's admission to meet the resident's immediate needs for one of the 6 sampled residents (Resident 4). This failure placed Resident 4's health at risk when resident's person centered care plan was not created upon admission. Findings: A review of Resident 4 ' s admission record stated he was admitted to the facility on [DATE], with diagnoses which include frequent falls, dysphagia and aphasia following a cerebral infarction (difficulty swallowing and talking following a stroke), muscle weakness, and dementia. A record review of Resident 4 ' s care plans, no baseline care plan was found in the record for the first admission on 6/29/24 for fall prevention, there was a baseline care plan on his readmission on 7/9/24. During a concurrent interview and clinical record review for Resident 4 with the Director of Nursing (DON), on 12/18/24 at 10:10 am, DON was unable to find documented evidence that a baseline care plan was developed within 48 hours of Resident 4's admission to the facility on [DATE]. DON stated the expectation would be that Resident 4's baseline care would be developed within 48 hours of the resident's admission to the facility but it was not done especially since he had a history of frequent falls. DON stated she was not aware of the severity of this residents past falls until his spouse updated them, about three days after his fall. Based on interview and record review the facility failed to develop a Person-Centered baseline care plan within 48 hours of a resident's admission to meet the resident's immediate needs for one of the 6 sampled residents (Resident 4). This failure placed Resident 4's health at risk when resident's person centered care plan was not created upon admission. Findings: A review of Resident 4's admission record stated he was admitted to the facility on [DATE], with diagnoses which include frequent falls, dysphagia and aphasia following a cerebral infarction (difficulty swallowing and talking following a stroke), muscle weakness, and dementia. A record review of Resident 4's care plans, no baseline care plan was found in the record for the first admission on 6/29/24 for fall prevention, there was a baseline care plan on his readmission on 7/9/24. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and clinical record review for Resident 4 with the Director of Nursing (DON), on 12/18/24 at 10:10 am, DON was unable to find documented evidence that a baseline care plan was developed within 48 hours of Resident 4's admission to the facility on [DATE]. DON stated the expectation would be that Resident 4's baseline care would be developed within 48 hours of the resident's admission to the facility but it was not done especially since he had a history of frequent falls. DON stated she was not aware of the severity of this residents past falls until his spouse updated them, about three days after his fall.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32797 Based on interview and record review the facility to ensure one of six residents (Resident 4) had a plan of care to meet his pain management needs after a fall with substantial injury. This resulted in untreated severe pain and a delay in treatment. Findings: A review of the facility ' s policy titled, Pain management, revised November 2016, indicated: Facility staff will help the resident attain or maintain their highest level of well being while working to prevent or manage the resident ' s pain to the extent possible. Procedure includes a licensed nurse will assess each resident for pain upon admission, quarterly, when there is a new onset of pain, exacerbation of pain, or when there is a change in status. If the Licensed Nurse is unable to determine if the resident's nonverbal cures are related to pain, the nurse will advise the Attending Physician and Interdisciplinary Team {IDT), so that the Attending Physician can consider ordering a trial pain medication to alleviate symptoms or identify another underlying cause for the nonverbal cues. A review of Resident 4 ' s admission record indicated he was admitted to the facility on [DATE] with diagnoses which included dysphagia and aphasia following a cerebral infarction (difficulty swallowing and talking following a stroke), muscle weakness, frequent falls at home and dementia. A review of Residents 4 ' s admission notes on 6/29/24 at 1:24 pm by a Licensed Nurse (LN) indicated resident had no pain on admission. A review of Resident 4 ' s nursing progress note dated 7/1/24 at 5:06 am indicated Resident 4 had an unwitnessed fall at 4:45 am on 7/1/24. Resident 4 was found on the floor with wet brief twisted around his feet. LN documented Resident has new injury of skin tear between left thumb and fingers, and new pain with movement. A review of Resident 4 ' s physician orders dated 6/29/24, indicated to administer Acetaminophen (mild pain medication) 325 milligrams (mg) 2 tabs every 6 hours as needed for mild pain (1-3 on pain scale of 10) A record review dated 7/1/24 at 1:54 pm, LN documented physical therapist reported Resident 4 yelling out and guarded pain to right hip with movement. New order for x-ray to right hip. A review of the Medication Administration Record (MAR) dated 7/1/24 at 8:33 am, Resident 4 was assessed for 3 out of 10 (mild pain). On 7/1/24 at 8:05 pm, he was assessed for 4 out of 10 (moderate pain) and received Acetaminophen 2 tabs. A record review dated 7/2/24 12:29 am, LN documented that Resident 1 yelling and guarding when turned or when right lower extremity was moved. Resident 4 continues to yell out during care, calling out to staff repeatedly but unable to state what he needs. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another record review of 72-hour admission notes on 7/2/24 at 12:26 am, 18 hours post fall Resident 4 was alert, oriented to self only, unable to make needs known. LN documented Resident 4 calls out frequently during care. On monitoring for fall at 4:45 am, yells when turned. A record review of Resident 4 ' s progress note dated 7/2/24 at 8:29 am indicated resident yelling and guarding (protecting the injured area) when turned or right lower extremity moved. Resident 4 continued to yell out during care, calling out to staff repeatedly but unable to state needs. Record review of alert note on 7/2/24 at 10:10 am, indicated the x-ray completed, possible fracture to right hip, Medical Director (MD) notified, verbal order given to send out to acute care hospital. Emergency medical services transported Resident 4 to hospital for treatment at 10:35 am. Further record review showed Resident 4 return to facility on 7/9/24, new physician order for Tramadol (pain medication for moderate to severe pain) 50 mg ordered every 6 hours as needed for moderate (4-7 out of 10 pain) and severe (8-10) pain. A new order for Lorazepam (Ativan, antianxiety medication) 0.5 mg two times a day for anxiety as evidenced by inability to relax. During an interview with Licensed Vocational Nurse (LVN A), on 11/20/24 at 11:30 am, LVN A stated she remembers resident on admission to be very confused unable to stated pain level and hollering out often. LVN A stated this can be a sign of pain. During an interview with Director of Nursing (DON) on 12/18/24 at 10:10 am she stated that typically when X-rays are ordered they are done and they get the results quickly, within a few hours. DON confirmed the x-ray should have been done timely. DON stated she would expect the physician should have been notified of the severe pain and had a stronger pain medication to alleviate his pain. Based on interview and record review the facility to ensure one of six residents (Resident 4) had a plan of care to meet his pain management needs after a fall with substantial injury. This resulted in untreated severe pain and a delay in treatment. Findings: A review of the facility's policy titled, Pain management , revised November 2016, indicated: Facility staff will help the resident attain or maintain their highest level of well being while working to prevent or manage the resident's pain to the extent possible. Procedure includes a licensed nurse will assess each resident for pain upon admission, quarterly, when there is a new onset of pain, exacerbation of pain, or when there is a change in status. If the Licensed Nurse is unable to determine if the resident's nonverbal cures are related to pain, the nurse will advise the Attending Physician and Interdisciplinary Team {IDT), so that the Attending Physician can consider ordering a trial pain medication to alleviate symptoms or identify another underlying cause for the nonverbal cues. A review of Resident 4's admission record indicated he was admitted to the facility on [DATE] with diagnoses which included dysphagia and aphasia following a cerebral infarction (difficulty swallowing and talking following a stroke), muscle weakness, frequent falls at home and dementia. A review of Residents 4's admission notes on 6/29/24 at 1:24 pm by a Licensed Nurse (LN) indicated resident had no pain on admission. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 4's nursing progress note dated 7/1/24 at 5:06 am indicated Resident 4 had an unwitnessed fall at 4:45 am on 7/1/24. Resident 4 was found on the floor with wet brief twisted around his feet. LN documented Resident has new injury of skin tear between left thumb and fingers, and new pain with movement. A review of Resident 4's physician orders dated 6/29/24, indicated to administer Acetaminophen (mild pain medication) 325 milligrams (mg) 2 tabs every 6 hours as needed for mild pain (1-3 on pain scale of 10) A record review dated 7/1/24 at 1:54 pm, LN documented physical therapist reported Resident 4 yelling out and guarded pain to right hip with movement. New order for x-ray to right hip. A review of the Medication Administration Record (MAR) dated 7/1/24 at 8:33 am, Resident 4 was assessed for 3 out of 10 (mild pain). On 7/1/24 at 8:05 pm, he was assessed for 4 out of 10 (moderate pain) and received Acetaminophen 2 tabs. A record review dated 7/2/24 12:29 am, LN documented that Resident 1 yelling and guarding when turned or when right lower extremity was moved. Resident 4 continues to yell out during care, calling out to staff repeatedly but unable to state what he needs. Another record review of 72-hour admission notes on 7/2/24 at 12:26 am, 18 hours post fall Resident 4 was alert, oriented to self only, unable to make needs known. LN documented Resident 4 calls out frequently during care. On monitoring for fall at 4:45 am, yells when turned. A record review of Resident 4's progress note dated 7/2/24 at 8:29 am indicated resident yelling and guarding (protecting the injured area) when turned or right lower extremity moved. Resident 4 continued to yell out during care, calling out to staff repeatedly but unable to state needs. Record review of alert note on 7/2/24 at 10:10 am, indicated the x-ray completed, possible fracture to right hip, Medical Director (MD) notified, verbal order given to send out to acute care hospital. Emergency medical services transported Resident 4 to hospital for treatment at 10:35 am. Further record review showed Resident 4 return to facility on 7/9/24, new physician order for Tramadol (pain medication for moderate to severe pain) 50 mg ordered every 6 hours as needed for moderate (4-7 out of 10 pain) and severe (8-10) pain. A new order for Lorazepam (Ativan, antianxiety medication) 0.5 mg two times a day for anxiety as evidenced by inability to relax. During an interview with Licensed Vocational Nurse (LVN A), on 11/20/24 at 11:30 am, LVN A stated she remembers resident on admission to be very confused unable to stated pain level and hollering out often. LVN A stated this can be a sign of pain. During an interview with Director of Nursing (DON) on 12/18/24 at 10:10 am she stated that typically when X-rays are ordered they are done and they get the results quickly, within a few hours. DON confirmed the x-ray should have been done timely. DON stated she would expect the physician should have been notified of the severe pain and had a stronger pain medication to alleviate his pain

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 32797 Based on observation, interview, and record review, the facility failed to ensure dietary staff followed the dietary menus and a recipe for a lunch meal when: 1. An unapproved substitute meal was provided without reasonable effort made to ensure nutritional adequacy. 2. A recipe was not followed for creamy rice. This had the potential for all residents not to receive their nutritional requirements to maintain normal body weight. Findings: A review of a facility policy titled Menu Operational Manual Procedure, revised 04/01/2014, indicated food service should adhere to the written menu. Substitutions to the menu should be comparable in nutritional value taking into consideration vitamins, minerals, and calories. Substitutions should also be reviewed by the Dietary Manager and Dietitian for appropriateness per the diet order and recorded on Form A - Substitution List. 1. During a concurrent observation, interview and record review on 11/08/24 at 12:10 pm, a meal tray line was observed. A review of the menu dated 11/08/2024, indicated baked tilapia, creamy rice, tartar sauce, mixed vegetables, chocolate mousse, and milk/beverage. A menu change was observed, the rice served was not creamy. The [NAME] (CK) stated they did not have the required ingredient of cream for the rice recipe. CK confirmed the recipe was not followed and the Certified Dietary Manager (CDM) nor the Registered Dietician (RD) were consulted about the change. 2. During a concurrent observation, interview on 11/08/24 at 12:10 pm, CK substituted the baked tilapia for a meal of ravioli during lunch tray line. CK explained she chose the substitution due to it being available. CK confirmed the ravioli was not selected from a spreadsheet that had been reviewed for nutritional adequacy as a comparable substitute. CK confirmed the meal exchange was not followed and the CDM nor the RD were consulted about the change. During an interview on 11/20/24 10:05 pm, CDM explained space was limited for items that would be ordered in a case, items are purchased locally outside of the food orders. She stated this was the case for the changes made in the menu on 11/08/24, that she was not able to purchase the ingredients for the creamy rice due to being out sick. When a food substitution is made it should be reported to the dietician via form. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24 at 10:40 am, RD stated the transition to the new menu system had been challenging for staff because there are more places to look for menu information. RD explained that the last system, the [NAME] could make changes to the menu based on supply, but they needed to use a spreadsheet system to ensure nutritional equivalents are in place. RD confirmed the changes made to the menu should be kept in a log where she can review them. RD agreed the dietary staff should know who to notify regarding changes when management was not available. Based on observation, interview, and record review, the facility failed to ensure dietary staff followed the dietary menus and a recipe for a lunch meal when: 1. An unapproved substitute meal was provided without reasonable effort made to ensure nutritional adequacy. 2. A recipe was not followed for creamy rice. This had the potential for all residents not to receive their nutritional requirements to maintain normal body weight. Findings: A review of a facility policy titled Menu Operational Manual Procedure , revised 04/01/2014, indicated food service should adhere to the written menu. Substitutions to the menu should be comparable in nutritional value taking into consideration vitamins, minerals, and calories. Substitutions should also be reviewed by the Dietary Manager and Dietitian for appropriateness per the diet order and recorded on Form A - Substitution List. 1. During a concurrent observation, interview and record review on 11/08/24 at 12:10 pm, a meal tray line was observed. A review of the menu dated 11/08/2024, indicated baked tilapia, creamy rice, tartar sauce, mixed vegetables, chocolate mousse, and milk/beverage. A menu change was observed, the rice served was not creamy. The [NAME] (CK) stated they did not have the required ingredient of cream for the rice recipe. CK confirmed the recipe was not followed and the Certified Dietary Manager (CDM) nor the Registered Dietician (RD) were consulted about the change. 2. During a concurrent observation, interview on 11/08/24 at 12:10 pm, CK substituted the baked tilapia for a meal of ravioli during lunch tray line. CK explained she chose the substitution due to it being available. CK confirmed the ravioli was not selected from a spreadsheet that had been reviewed for nutritional adequacy as a comparable substitute. CK confirmed the meal exchange was not followed and the CDM nor the RD were consulted about the change. During an interview on 11/20/24 10:05 pm, CDM explained space was limited for items that would be ordered in a case, items are purchased locally outside of the food orders. She stated this was the case for the changes made in the menu on 11/08/24, that she was not able to purchase the ingredients for the creamy rice due to being out sick. When a food substitution is made it should be reported to the dietician via form. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24 at 10:40 am, RD stated the transition to the new menu system had been challenging for staff because there are more places to look for menu information. RD explained that the last system, the [NAME] could make changes to the menu based on supply, but they needed to use a spreadsheet system to ensure nutritional equivalents are in place. RD confirmed the changes made to the menu should be kept in a log where she can review them. RD agreed the dietary staff should know who to notify regarding changes when management was not available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055516	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chico Terrace Care Center	188 Cohasset Lane Chico, CA 95926

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32797 Based on observation, interview, and record review, the facility failed to provide food that is palatable (refers to the taste and/or flavor of the food), attractive, and nutritious. Complaints of food that is not appetizing or palatable for three of five (Residents 3, 5 and 6). This had the potential for all residents to receive an inadequate amount of nutrition required to aid in the recovery from illness or injury or maintain a healthy body weight. Findings: A review of a facility policy titled Menu Operational Manual Policy, revised 04/01/2014, The Dietary Manager will develop menus in collaboration with the Dietitian. Menus are to be designed in consideration of resident preferences, Dietary Department resources, and seasonal availability of food. A record review of monthly Resident Council Meeting minutes from 6/26/24 to 10/24/24, included complaint/concerns regarding food including not liking the new food, wishing they had a different menu, and the food being too cold to consume. A record review of a Food & Nutrition: Resident Satisfaction Survey completed on 9/3/24, had several comments of the food having poor overall quality, food is served cold, and poor presentation of the food. Comments include menus are bad, food used to be better between March - May 2024, food was disgusting, not enough food on the plate, milk is old, getting tired of turkey and chicken, sometimes food is repeated too much, and coffee is always cold. During an interview with Resident 3 on 10/30/24 at 2:55 pm stated the food was terrible, they do not follow the menu, the food is cold, and the chef does not know how to cook. During an interview with Resident 5 on 10/30/24 at 12:30 pm she stated, I have been in a lot of hospitals, and this is the worst food I have ever had. The cooks don ' t know how to cook. The chicken is dry like a hockey puck. Noodles are dry. I won ' t touch the rice. I am lucky because I have friends and family to bring me food. Veggies are always mushy. Food has no flavor. Fish is ok with a lot of tartar sauce. During an interview on 10/30/24 at 12:40 pm, Resident 5 stated she refused the lunch entree of fish today because it has no flavor and needs too much tartar sauce to be palatable, so she requested a grilled cheese sandwich instead. She stated veggies are usually mushy, the rice is always too dry to eat, often gets cold food and food does not have good flavor. During an interview on 11/20/24 at 10:05 am, with the Certifiied Dietary Manager (CDM) stated she had received complaints from residents that included food not being appealing, too many cold plates, food not identifiable, chicken served too frequently, and meal not appearing complete. CDM felt this was related to the recent switch of food services. CDM stated she feels they are the [NAME] pig with this new menu system. The spreadsheet they use to ensure nutritional equivalent was not accurate which confuses the cooks. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Regional Dietician (RD) on 12/18/24 at 10:40 am she stated she was part of the implementation of the new menu system being used in the facility. RD stated she has not interviewed the residents but has communicated with the facility management often. RD stated the transition has been challenging for staff because there are more places to look for menu information. RD explained that the last system, the cook could make changes to the menu based on supply, but they needed to use a spreadsheet system to ensure nutritional equivalents are in place. RD confirmed the changes made to the menu should be kept in a log where she can review them. RD agreed the staff should know who to notify regarding changes when management was not available. Based on observation, interview, and record review, the facility failed to provide food that is palatable (refers to the taste and/or flavor of the food), attractive, and nutritious. Complaints of food that is not appetizing or palatable for three of five (Residents 3, 5 and 6). This had the potential for all residents to receive an inadequate amount of nutrition required to aid in the recovery from illness or injury or maintain a healthy body weight. Findings: A review of a facility policy titled Menu Operational Manual Policy , revised 04/01/2014, The Dietary Manager will develop menus in collaboration with the Dietitian. Menus are to be designed in consideration of resident preferences, Dietary Department resources, and seasonal availability of food. A record review of monthly Resident Council Meeting minutes from 6/26/24 to 10/24/24, included complaint/concerns regarding food including not liking the new food, wishing they had a different menu, and the food being too cold to consume. A record review of a Food & Nutrition: Resident Satisfaction Survey completed on 9/3/24, had several comments of the food having poor overall quality, food is served cold, and poor presentation of the food. Comments include menus are bad, food used to be better between March - May 2024, food was disgusting, not enough food on the plate, milk is old, getting tired of turkey and chicken, sometimes food is repeated too much, and coffee is always cold. During an interview with Resident 3 on 10/30/24 at 2:55 pm stated the food was terrible, they do not follow the menu, the food is cold, and the chef does not know how to cook. During an interview with Resident 5 on 10/30/24 at 12:30 pm she stated, I have been in a lot of hospitals, and this is the worst food I have ever had . The cooks don't know how to cook . The chicken is dry like a hockey puck . Noodles are dry . I won't touch the rice . I am lucky because I have friends and family to bring me food . Veggies are always mushy . Food has no flavor . Fish is ok with a lot of tartar sauce . During an interview on 10/30/24 at 12:40 pm, Resident 5 stated she refused the lunch entree of fish today because it has no flavor and needs too much tartar sauce to be palatable, so she requested a grilled cheese sandwich instead. She stated veggies are usually mushy , the rice is always too dry to eat, often gets cold food and food does not have good flavor. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/24 at 10:05 am, with the Certifiied Dietary Manager (CDM) stated she had received complaints from residents that included food not being appealing, too many cold plates, food not identifiable, chicken served too frequently, and meal not appearing complete. CDM felt this was related to the recent switch of food services. CDM stated she feels they are the [NAME] pig with this new menu system. The spreadsheet they use to ensure nutritional equivalent was not accurate which confuses the cooks. During an interview with the Regional Dietician (RD) on 12/18/24 at 10:40 am she stated she was part of the implementation of the new menu system being used in the facility. RD stated she has not interviewed the residents but has communicated with the facility management often. RD stated the transition has been challenging for staff because there are more places to look for menu information. RD explained that the last system, the cook could make changes to the menu based on supply, but they needed to use a spreadsheet system to ensure nutritional equivalents are in place. RD confirmed the changes made to the menu should be kept in a log where she can review them. RD agreed the staff should know who to notify regarding changes when management was not available.

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(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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32797 Based on observation, interview, and record review, the facility failed to ensure a food was prepared in a safe and sanitary kitchen in accordance with professional food standards when: 1. Food was stored in a refrigerator that was not maintained at the required temperatures for storage. 2. Food storage containers were stacked wet and available for use. 3. A soiled towel was used around a floor drain to prevent splashing. This had the potential to put all residents at risk for food borne illness. Findings: 1. A record review of Facility Visit Report - Nutritional Services dated 09/26/24, the Registered Dietician (RD) kitchen audit identified an issue of concern that the [NAME] refrigerator inside temperature was 45 degrees F. During a concurrent observation and interview on 11/08/24 at 12:30 pm, Dietary Aide (DA) confirmed the [NAME] double door fridge inside temperature was 49 degrees Fahrenheit (F). During a concurrent observation and interview on 11/20/2024 at 9:55 am, the inside temperature of the double door [NAME] refrigerator was observed to be 44 degrees F. Certified Dietary Manager (CDM) confirmed that 44 degrees did not meet regulation for food safety, should be less than 40 degrees F. 2. A record review of Facility Visit Report - Nutritional Services dated 8/1/24, the RD kitchen audit identified an issue of concern that the use of a towel on the floor around the dishwasher drain had splatter from dirty water, and a floor drain that was black and in need of cleaning. A record review of Facility Visit Report - Nutritional Services dated 09/26/24, the RD kitchen audit identified an issue of concern when the floor drain under the dish machine splashes dirty water and that a towel was placed on the ground. During an observation and interview on 11/08/2024, a soiled towel was observed around a floor drain under a dishwasher. Dietary Aide (DA) stated that the towel was wrapped around the drain to prevent water from splashing and that they have been using this method for months. Another observation on 11/20/24 at 9:55 am, a dirty towel was seen wrapped around the dishwasher drain. During a concurrent observation and interview 12/13/24 at 3;15 pm, the Maintenance Director (MND) stated the towel wrapped around the air gap for the dishwasher drain to catch the splashing had been there about [AGE] years. must prioritize maintenance jobs by those that affect patient safety first. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent observation and interview on 11/08/24 at 1230 pm, DA confirmed the plastic storage bins were wet and sitting on a shelf and stated they should not put on the shelf wet. During a concurrent observation and interview on 11/20/2024 at containers that would be used to store and prepare food were observed stacked wet. Certified Dietary Manager (CDM) confirmed that the containers were wet and that they are used for food storage and preparation and dietary staff should let them air dry before stacking them for use. CDM confirmed that having a dirty splashing water and a wet dirty towel in the kitchen under the dishwasher was not sanitary. Based on observation, interview, and record review, the facility failed to ensure a food was prepared in a safe and sanitary kitchen in accordance with professional food standards when: 1. Food was stored in a refrigerator that was not maintained at the required temperatures for storage. 2. Food storage containers were stacked wet and available for use. 3. A soiled towel was used around a floor drain to prevent splashing. This had the potential to put all residents at risk for food borne illness. Findings: 1. A record review of Facility Visit Report - Nutritional Services dated 09/26/24, the Registered Dietician (RD) kitchen audit identified an issue of concern that the [NAME] refrigerator inside temperature was 45 degrees F. During a concurrent observation and interview on 11/08/24 at 12:30 pm, Dietary Aide (DA) confirmed the [NAME] double door fridge inside temperature was 49 degrees Fahrenheit (F). During a concurrent observation and interview on 11/20/2024 at 9:55 am, the inside temperature of the double door [NAME] refrigerator was observed to be 44 degrees F. Certified Dietary Manager (CDM) confirmed that 44 degrees did not meet regulation for food safety, should be less than 40 degrees F. 2. A record review of Facility Visit Report - Nutritional Services dated 8/1/24, the RD kitchen audit identified an issue of concern that the use of a towel on the floor around the dishwasher drain had splatter from dirty water, and a floor drain that was black and in need of cleaning. A record review of Facility Visit Report - Nutritional Services dated 09/26/24, the RD kitchen audit identified an issue of concern when the floor drain under the dish machine splashes dirty water and that a towel was placed on the ground. During an observation and interview on 11/08/2024, a soiled towel was observed around a floor drain under a dishwasher. Dietary Aide (DA) stated that the towel was wrapped around the drain to prevent water from splashing and that they have been using this method for months. Another observation on 11/20/24 at 9:55 am, a dirty towel was seen wrapped around the dishwasher drain. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview 12/13/24 at 3;15 pm, the Maintenance Director (MND) stated the towel wrapped around the air gap for the dishwasher drain to catch the splashing had been there about [AGE] years. must prioritize maintenance jobs by those that affect patient safety first. 3. During a concurrent observation and interview on 11/08/24 at 1230 pm, DA confirmed the plastic storage bins were wet and sitting on a shelf and stated they should not put on the shelf wet. During a concurrent observation and interview on 11/20/2024 at containers that would be used to store and prepare food were observed stacked wet. Certified Dietary Manager (CDM) confirmed that the containers were wet and that they are used for food storage and preparation and dietary staff should let them air dry before stacking them for use. CDM confirmed that having a dirty splashing water and a wet dirty towel in the kitchen under the dishwasher was not sanitary.