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	03/03/2025

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on interview and record review, the facility failed to ensure a Care Conference meeting, to determine that a resident may be appropriate for a facility initiated discharge, occurred with the Interdisciplinary Team (IDT, a group of healthcare professionals nurses, therapists, social workers, dietitians and activities staff who work together to plan the residents care), Physician, the resident and resident ' s responsible party (RP, an individual who assumes varying degrees of responsibility for the well-being of the resident) for one of two sampled residents (Resident 1) when Resident 1 ' s RP indicated she never had a meeting with the facility about Resident 1 ' s discharge therapy levels or training on how to assist Resident 1 with his mobility at home and Resident 1 was unable to make it into the house and could not stand or transfer. This failure had the potential for a decline in Resident 1 ' s physical, psychosocial, and mental well-being after discharge from the facility. Findings: A review of the facility ' s policy titled Transfer and Discharge revised 7/2/20, indicated (1) (F) If the IDT team and the Attending Physician determine that the resident may be appropriate for discharge, Social Services staff will coordinate the discussion of discharge with IDT, the resident and the responsible party. (1)(J) Social Service Staff may coordinate a care conference to discuss discharge needs, plans, and teaching, and will involve other IDT members as appropriate. A review of Resident 1 ' s admission record indicated Resident 1 was originally admitted on [DATE] with diagnoses that included two fractures of the left leg, fracture of the fifth cervical (neck) vertebra (bone that makes up the spine), parkinsonism (a group of symptoms that include: slowness of movement, stiffness of muscles, and involuntary shaking movements), difficulty in walking, prostate cancer, anemia (low red blood cells), dementia (decrease ability to think, recall and make decisions), depression, and repeated falls. On 12/13/24 Resident 1 was transferred to the hospital due to a sustained fracture of the lower back from a fall while in the facility. On 12/16/24 Resident 1 was readmitted to the facility. Resident 1 ' s RP made health care decisions for him. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s admission Minimum Data Set (MDS, assessment tool to evaluate residents) dated 12/23/24, indicated Resident 1 ' s Brief Interview For Mental Status (BIMS, a tool to assess cognition [thinking, reasoning, and memory recall]) score was 8 which indicated moderate cognitive impairment. Section GG (which describes the residents ' ability to perform self-care [activities of daily living] and mobility items) indicated Resident 1 required moderate assistance with upper body dressing and personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, washing/drying face and hands). Resident 1 required maximal assistance with lower body dressing, toileting hygiene (cleaning self after going to the bathroom), showering, rolling left and right in bed, sitting to lying position, sitting to standing position, chair/ bed-chair transfer, and toilet transfer. Resident 1 was dependent for lying to sitting on the side of the bed and walking 10 feet was not attempted due to medical condition or safety concerns. A review of Resident 1 ' s progress note dated 1/7/25 at 12:14 pm, Social Service Director (SSD) documented SSD spoke with Resident ' s spouse, discussing options for discharge, Spouse is very worried about Resident ' s High Fall Risk, but shares she is confident she can manage his care alongside Home Health. She is wavering but is still discussing with Resident ' s family as they are concerned as well. A review of Resident 1 ' s progress note dated 1/14/25 at 11:25 am, indicated Patient discharged to home leaving facility at 11:20 am, with wife and son in attendance. During an interview with Family Member (FM) B on 2/4/25 at 8:59 am, FM B indicated that Resident 1 was discharged from the facility to home on 1/14/25 and was unable to make it into his house and could not stand or transfer. FM B indicated there was never a discharge meeting with the facility about his discharge abilities to determine if Resident 1 was appropriate for discharge. During a review of Resident 1 ' s Physical Therapy PT Discharge Summary filled out by the Physical Therapist Aide (PTA) for dates of service: 12/17/24 thru 1/13/24, discharge reason was discharged per Physician or Case Manager. The discharge summary indicated: *Resident 1 had not met the short-term goal of the ability to transfer from lying on the back to sitting on the side of the bed and with no back support Supervision or Touching Assistance in order to get in/out of bed and prepare for transfers. At discharge Resident 1 required substantial/maximal assistance (where helper does most of the work) to transfer from lying on the back to sitting on the side of the bed. *Five of five Long-Term therapy goals were not met upon discharge. *Resident 1 ' s living environment required him to step up one step to get into his house. One step (curb) was not attempted during therapy due to medical conditions or safety concerns. During a concurrent interview with PTA and record review on 2/4/25 at 2:51 pm, Resident 1 ' s Physical Therapy PT Discharge Summary was reviewed. PTA confirmed that Resident 1 had not met his therapy goals before discharge. PTA indicated she never saw Resident 1 walk due to him refusing therapy during his last two days in the therapy. During an interview with the Director of Rehabilitation (DOR) on 2/4/25 at 3:00 pm, DOR indicated Resident 1 ' s discharge was an impromptu because the wife wanted him to go home. The rehabilitation department was notified the day of Resident 1 ' s discharge that he was going home. The DOR indicated there was no training with the RP on how to assist Resident 1 with his needs. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25 at 10:46 am, Social Service Director (SSD) indicated Resident 1 was discharged from the facility on 1/14/25. SSD stated, We met in our Medicare meeting (a meeting with the DOR, Medical Record Director, SSD, MDS, Business Office Director and Administrator and discuss resident ' s level of care) and from that meeting I was given the go ahead to start the discharge process. SSD was unable to provide a documentation of this meeting or a date when it occurred for Resident 1. During an interview on 2/26/25 at 11:40 am, Certified Nursing Assistant (CNA) indicated that after Resident 1 ' s fall CNA never saw him walk. CNA stated, Some days he (Resident 1) could transfer and some days he was too unsteady, and I had to ask for a second pair of hands to transfer him. He (Resident 1) was not stable enough to go home with his RP. During an interview on 2/26/25 at 11:46 am, Licensed Nurse (LN) A indicated Resident 1 was not safe to go home. He had poor safety awareness. He could walk but he was unstable. LN A indicated she assumed that at the care conference meeting they would have discussed this with the family. LN A was unaware if there was a care conference meeting with the RP. During an interview on 2/28/25 at 8:56 am, Resident 1 ' s RP stated, I said to them (the facility) ' When he (Resident 1) is ready to be released, I will want him to go home. ' I would ask ' when are you going to release him? ' Then all of a sudden, I got a call from (SSD name), and she said we had our meeting, and he (Resident 1) is good to go home. RP indicated she had not attended a meeting about discharge and had not discussed with anyone at the facility about Resident 1 ' s therapy level. RP stated, He (Resident 1) could not stand or transfer when he came home. RP indicated she signed some papers but did not know what they were. RP indicated Resident 1 was unable to make it into the house and could not stand or transfer. RP indicated Resident 1 was not safe to come home and she would have insisted that he stay longer to receive therapy if she knew he was not strong enough or safe to come home. A review of Resident 1 ' s IDT Care Conference meetings identified two care conference meetings for Resident 1 ' s entire stay at the facility. One on 11/5/24 for admission which identified to have included a nurse, the dietary department, the social worker, the activities department, the physical therapist and a family member in attendance at the meeting. A second meeting was identified on 12/18/24 for the second admission which identified that no one was in attendance for the meeting, but templets had been filled out by the dietary, activity director, a nurse, and therapy. There was no record of Resident 1 ' s discharge IDT Care Conference Meeting as per the facility ' s policy titled Transfer and Discharge. During a concurrent interview and record review with the Director of Nursing (DON) on 3/3/25 at 3:44 pm, Resident 1 ' s IDT Care Conference meetings were reviewed. DON indicated there was no IDT Care Conference meeting with the family concerning Resident 1 ' s discharge, level of care or care giver training concerning physical help that was needed for Resident 1 and there should have been.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on interview and record review the facility failed to ensure they provided care and services for one of two residents (Resident 1) sampled for unplanned weight loss when: 1. Resident 1 was not weighed as per facility policy. 2. There was no weekly monitoring of Resident 1 ' s weight by an Interdisciplinary Team (IDT, a group of healthcare professionals nurses, therapists, social workers, dietitians and activities staff who work together to plan the residents care) the first 10 weeks after admission. 3. Care plan titled Nutritional problem or potential nutritional problem was not reviewed or revised to reflect an actual weight loss and no interventions were added to his care plan. These failures delayed care and services needed for Resident 1 to prevent weight loss and had the potential to add to the cause of Resident 1 ' s 18.8-pound weight loss in two months. Findings: A review of Resident 1 ' s admission record indicated Resident 1 was originally admitted on [DATE] with diagnoses that included two fractures of the left leg, fracture of the fifth cervical (neck) vertebra (bone that makes up the spine), parkinsonism (a group of symptoms that include: slowness of movement, stiffness of muscles, and involuntary shaking movements), difficulty in walking, prostate cancer, anemia (low red blood cells), dementia (decrease ability to think, recall and make decisions), depression, influenza on 12/23/24 (during his admission at the facility) and repeated falls. On 12/13/24 Resident 1 was transferred to the hospital due to a fracture of the lower back sustained from a fall while in the facility. On 12/16/24 Resident 1 was readmitted to the facility. Resident 1 ' s Responsible Party (RP, a person who makes health care decisions for a resident) made health care decisions for him. A review of Resident 1 ' s admission Minimum Data Set (MDS, assessment tool to evaluate residents) dated 11/11/24 indicated Resident 1 ' s Brief Interview For Mental Status (BIMS, a tool to assess cognition [thinking, reasoning, and memory recall]) score was 7 which indicated severe cognitive impairment. A review of section K (which describes swallowing and nutritional status of a resident) indicated Resident 1 weighed 172 pounds on admission, had complaints of difficulty or pain with swallowing and was put on a mechanical soft diet (a modified diet with foods that are soft, easy to mash and can be cut into small pieces). A review of section GG (which describes the residents ' ability to perform self-care [activities of daily living] and mobility items) indicated Resident 1 required set-up or clean up assistance with eating. A review of Resident 1 ' s Comprehensive Care Plan on admission revised on 11/15/24, indicated Resident 1 had a care plan titled Nutritional problem or potential nutritional problem related to . and then listed Resident 1 ' s diagnoses. Care Plan Goals documented for Resident 1 were to maintain adequate nutritional status as evidenced by maintain weight within 5% of admission weight. Interventions were as follows: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Monitor/record/report to MD (Medical Doctor) as needed for signs or symptoms of malnutrition (lack of nutrients): Emaciation (abnormally thin), muscle wasting, significant weight loss: a loss of three pounds in one week, greater than 5% (percent) weight loss in one month, and greater than 7.5% weight loss in three months. b. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. c. Provide, serve diet as ordered. Monitor intake and record every meal. d. Registered Dietitian (RD) to evaluate and make diet change recommendations as needed. e. Weight on admission, then weekly x 4, then monthly/as needed. 1. A review of the facility ' s policy titled Evaluation of Weight and Nutritional Status revised date 1/30/25, indicated 1. The facility will maintain an acceptable nutritional status for residents per professional standards Residents who are at risk (for weight loss) should be weighed weekly include (but not limited to) the following: 1) Admissions/readmissions for the first 4 weeks. A review of Resident 1 ' s weights for the first 4 weeks after admission on 11/4/25 included. *Admission weight on 11/4/24 = 172.2 lbs.(pounds). *Week one weight on 11/6/24 = 172.2 lbs. * Week two weight on 11/14/24 = 175.6 lbs. *No weights documented for week 3 (11/17/24 thru 11/ 23/24.) *No weights documented for week 4 (11/24/24 thru 11/30/24). *No weight was documented on readmission from the hospital on 12/16/24. During a concurrent interview with the [NAME] Registered Dietitian (RRD) and record review on 3/3/25 at 2:30 pm, Resident 1 ' s weight record was reviewed. RRD indicated there were no weights documented for Resident 1 after his admission for week three and week four and there should have been. RRD also confirmed that Resident 1 was not weighed on his readmission 12/16/25 after his hospital stay and he should have been. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of the facility ' s policy titled Evaluation of Weight and Nutritional Status revised date 1/30/25, indicated 1. The facility will maintain an acceptable nutritional status for residents per professional standards by: e) Monitoring and evaluating the resident ' s response, or the lack of response to interventions. f) revising or discontinuing the approaches as appropriate or justifying the continuation of current approaches. Definitions . b) Weight Loss - unplanned weight loss in a resident. Significant weight loss (5% and or 5 pound in a month, 7.5% in three months, or 10% in six month), as well as unplanned weight loss that occurs over time that does not meet the guidelines for significant weight loss Clinical Evaluation . b) Any resident weight that varies from the previous reporting period by 5% in 30 days, 7.5% in 90 days, 10% in 180 days, or is considered insidious (weight loss that occurs over time that does not meet the guidelines for significant weight loss) weight loss, will be evaluated by the IDT to determine the cause of weight loss/gain and the interventions required i) Once a weight gain or loss as described above is identified, the IDT will: 1. Identify and implement appropriate interventions; 2. Update and revise the Care Plan, as appropriate; 3. Notify the responsible party; 4. Notify the Attending Physician and 5. Notify the registered Dietitian d) Any resident meeting the criteria for physician prescribed weight loss and any resident at risk for weight loss or gain will be weighed and documented weekly. Weekly weights will be reviewed by the IDT. A continued review of Resident 1 ' s weight record during the time of his stay included: *12/1/24 weight = 168.6 lbs. *12/6/24 weight = 168.6 lbs. *12/13/24 weight = 164.8 lbs. (3.8 pounds lost in a week) *12/19/24 weight = 162.2 lbs. lbs. (10 pounds lost in a month equaling 5.81% loss) *12/26/24 weight = 158.2 lbs. (4 pounds lost in a week) *1/2/25 weight = 156.8 lbs. (11.8 pound lost for the month of December equaling a 6.99% weight loss) *1/9/25 weight = 153.4 lbs. (in two months, from 11/4/24 to 1/9/24 Resident 1 experienced an18.8-pound weight loss). A review of Resident 1 ' s weekly IDT weight variance meeting (meeting to discuss changes in a resident ' s weight) progress notes indicated there were no weekly IDT weight variance meetings for Resident 1 for the first 10 weeks after admission. There was no documentation of monitoring/recording or reporting to MD for the 3.8-pound weight loss in one week from 12/6/24 to 12/13/24 as per Resident 1 ' s intervention on his comprehensive care plan. There was no; 1. Identify and implement appropriate interventions; 2. Update and revise the Care Plan, as appropriate; 3. Notify the responsible party; 4. Notify the Attending Physician and 5. Notify the registered Dietitian when Resident 1 had a significant weight loss of 10 pounds in a month or 5.81 percent as noted on 12/19/25. Documented IDT weight variance meetings were done on: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*12/27/25, identified an 8% weight loss (14 lbs.) since admission weight (11/4/25). interventions were to continue interventions. Monitor weight weekly. Root cause: Resident 1 tested positive for influenza on 12/23/24 and was readmitted from acute on 12/17/24. *1/3/25, identified an 8.9% weight loss (15.4 lbs.) since admission weight. Food intake was 25-75%. New interventions were to continue interventions, Monitor weight weekly, Med Pass (a high calorie nutritional drink in a reduced portion size). *1/10/25, identified weight loss of 3.4 lbs. in one week. New interventions were to Fortify diet (a diet that has been enriched with essential nutrients, such as vitamins, minerals and other micronutrients) and weekly weight and continue interventions. During a concurrent interview with the [NAME] Registered Dietitian (RRD) and record review on 3/3/25 at 2:30 pm, Resident 1 ' s weights and IDT weight variance progress notes were reviewed. RRD indicated that Resident 1 had a 3.8 weight loss for week of 12/6/24 thru 12/13/24. RRD indicated that Resident 1 was sent to the hospital on 12/13/24 due to a fall and he returned on 12/16/24. RRD stated an IDT review for weights should have been done on 12/16/24 when Resident 1 returned, and it was not done. RRD continued to indicate that a nutrition assessment, implementing care plan interventions and notifying the MD should have been done concerning Resident 1 ' s weight loss according to his care plan. RRD indicated that the facility did not have a Registered Dietitian (RD) from dates 11/12/24 to 12/27/24, when the new RD was hired. The RRD stated I was available, but I do not tend to cover centers(facilities). The RRD indicated there was not an RD covering and checking weights during that time. The facility is in charge and the IDT would be responsible for checking weights and updating the care plans. 3. A review of the facility ' s policy titled Comprehensive Person-Centered Care Planning revised November 2018, indicated, .the comprehensive care plan will also be reviewed and revised at the following times: i) Onset of new problems; ii) Change of condition A review of Resident 1 ' s care plans indicated there was no reviewed or revised weight loss care plan with implemented interventions to prevent weight loss for Resident 1. During a concurrent interview with the MDS Licensed Nurse (MDS LN) and record review on 2/28/25 at 3:55 pm, MDS LN indicated weight care plans were revised by the IDT weight variance team, (Registered Dietitian) RD, or the Director of Nursing (DON). MDS LN reviewed Resident 1 ' s Care Plans and indicated that there was not a weight loss care plan for Resident 1 and there were no updates with new interventions in his nutritional care plan. During a concurrent interview with the [NAME] Registered Dietitian (RRD) and record review on 3/3/25 at 2:30 pm, Resident 1 ' s care plan was reviewed. RRD confirmed that Resident 1 ' s care plan had not been reviewed and revised concerning his weight loss and it should have been. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview with the Director of Nursing (DON) and record review on 3/3/25 at 3:31 pm, Resident 1 ' s weights, IDT weight variance meetings and care plans were reviewed. The DON indicated he just started at the facility on 11/11/24 and he was not looking at weights in November and early December. Resident 1 ' s IDT weight variance meetings were reviewed, and DON indicated that Resident 1 ' s weight was trending down and there should have been an IDT weight variance meeting on readmission and there was not one done. Resident 1 ' s care plans were reviewed, and DON indicated there should have been an actual weight loss care plan with interventions implemented and there was not. DON stated, the missing weights and missing weekly weight IDT meetings was probably because of not having an RD and half of the IDT team was newer.