

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055516	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2025
NAME OF PROVIDER OR SUPPLIER Chico Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview and record review, the facility failed to prevent abuse to one resident (RES1), when a Licensed Nurse at the facility (LVN1) was verbally abusive while providing care to RES1. This failure had the potential to cause harm to all residents residing in the facility that had contact with LVN1.</p> <p>Findings:</p> <p>During a review of a facility policy titled, Abuse Prevention, Screening and Training Program, last revised 7/1/18, and in effect, indicated that the facility did not condone any form of abuse and would provide an environment free of abuse to all residents. Verbal abuse was defined as any oral, written, or gestured communication that is belittling or derogatory and directed at any resident regardless of age, ability to comprehend, or disability.</p> <p>During a review of a nursing progress note by LVN1 on 5/16/25, at 10:57 PM, it was indicated that education about the importance of nutrition for health and to rebuild strength was provided to RES1.</p> <p>During an interview on 5/29/25, at 11:17 AM, the Director of Staff Development (DSD) indicated that RES1's family brought in yogurt, that yogurt was a food preference choice made by RES1, that yogurt was a good source of protein, and that RES1 had been encouraged to choose foods high in protein. The DSD confirmed that LVN1 had documented in the medical record that RES1 had been educated about nutrition.</p> <p>During an interview on 5/29/25, at 11:18 AM, the DSD stated that LVN1 had worked at the facility since 1/17/22 and had completed the mandatory facility abuse training each year of employment. The DSD also stated that a facility investigation was completed after RES1's family reported that LVN1 had stated to RES1, you are going to leave here in a pine box. The DSD stated that LVN1 had provided dietary education to RES1 that included the statement, if you do not eat, you will die. The DSD stated that the statement LVN1 made to RES1 was abuse and indicated that LVN1 should not have made abusive statements to any resident.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and concurrent employee file review with the Director of Nursing (DON), on 5/29/25, at 11:29 AM, the DON stated that LVN1 had made an abusive statement to RES1, that the abuse was overheard by another staff member, and that LVN1 had been placed on leave. The DON stated that LVN1 should not have made statements about death to RES1 while providing dietary education. A review of a document titled, Corrective Action Memo in LVN1's employee file indicated that the statements made by LVN1 were unacceptable, unprofessional, and a direct violation of the facility standards of care, resident rights, and abuse prevention policy. The DON stated that LVN1 had resigned from the facility.</p> <p>Based on interview and record review, the facility failed to prevent abuse to one resident (RES1), when a Licensed Nurse at the facility (LVN1) was verbally abusive while providing care to RES1. This failure had the potential to cause harm to all residents residing in the facility that had contact with LVN1.</p> <p>Findings:</p> <p>During a review of a facility policy titled, Abuse Prevention, Screening and Training Program, last revised 7/1/18, and in effect, indicated that the facility did not condone any form of abuse and would provide an environment free of abuse to all residents. Verbal abuse was defined as any oral, written, or gestured communication that is belittling or derogatory and directed at any resident regardless of age, ability to comprehend, or disability.</p> <p>During a review of a nursing progress note by LVN1 on 5/16/25, at 10:57 PM, it was indicated that education about the importance of nutrition for health and to rebuild strength was provided to RES1.</p> <p>During an interview on 5/29/25, at 11:17 AM, the Director of Staff Development (DSD) indicated that RES1's family brought in yogurt, that yogurt was a food preference choice made by RES1, that yogurt was a good source of protein, and that RES1 had been encouraged to choose foods high in protein. The DSD confirmed that LVN1 had documented in the medical record that RES1 had been educated about nutrition.</p> <p>During an interview on 5/29/25, at 11:18 AM, the DSD stated that LVN1 had worked at the facility since 1/17/22 and had completed the mandatory facility abuse training each year of employment. The DSD also stated that a facility investigation was completed after RES1's family reported that LVN1 had stated to RES1, you are going to leave here in a pine box. The DSD stated that LVN1 had provided dietary education to RES1 that included the statement, if you do not eat, you will die. The DSD stated that the statement LVN1 made to RES1 was abuse and indicated that LVN1 should not have made abusive statements to any resident.</p> <p>During an interview and concurrent employee file review with the Director of Nursing (DON), on 5/29/25, at 11:29 AM, the DON stated that LVN1 had made an abusive statement to RES1, that the abuse was overheard by another staff member, and that LVN1 had been placed on leave. The DON stated that LVN1 should not have made statements about death to RES1 while providing dietary education. A review of a document titled, Corrective Action Memo in LVN1's employee file indicated that the statements made by LVN1 were unacceptable, unprofessional, and a direct violation of the facility standards of care, resident rights, and abuse prevention policy. The DON stated that LVN1 had resigned from the facility.</p>		