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	01/21/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one of three (Resident 1), who spoke Spanish was explained what medications were being administered to them in a language they understood. This failure had the potential to result in violating the resident's right to be informed of their treatment. Findings:During a review of Resident 1's medical record indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses that included sepsis (a serious condition in which the body responds improperly to an infection), pneumonia (lung inflammation caused by an infection), and end stage renal disease (the kidneys no longer work as they should to meet the needs of one's body). Resident 1's primary language is Spanish. During a review of Resident 1's Care Plan Report located in Resident 1's electronic health record, indicated that on 11/26/25 Resident 1 was identified as having potential communication problem related to language barrier of primary language Spanish. , and the plan was to, Provide interpreter or use language line. During an interview on 12/23/25 at 3:07 pm with the Director of Nursing (DON), the DON confirmed that Resident 1 is Spanish Speaking. The DON's expectation for nursing staff is to explain to residents what medications they are taking in their own language. The DON would expect nursing staff to use Spanish speaking staff or use the facility interpreter service to communicate with Resident 1. During an interview on 12/23/25 at 3:19pm with Licensed Nurse (LN) A, LN A confirmed that Resident 1 is Spanish Speaking and that LN A does not speak Spanish. LN A stated that only sometimes will they use Spanish speaking staff to communicate with Resident 1, and they do not always explain to Resident 1 what medications he is taking. During an interview on 12/23/25 at 3:46 pm with CNA A, CNA A stated that she is Spanish speaking and staff will occasionally use them to help translate for Resident 1 but she has not recently done any translating for Resident 1 regarding their medications. During an interview on 12/23/25 at 3:57 pm with Resident 1, Resident 1 stated that staff do not always get a translator for them, and if they need one it can take up to 30 minutes. Resident 1 states that nursing staff do not always tell him what medications he is taking, and he will just take them even if he does not know what they are. Resident 1 feels that communication with staff about his condition has been poor and they would like the nursing staff to come in and answer their questions and give them an update.

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 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** Based on interview and record review, the facility failed to notify the physician of a change of condition for one of three sampled residents (Resident 1), when Resident 1 was having loose stools for eight days before the physician was notified. This failure resulted in the physician being unaware of Resident 1's condition and unable to evaluate the resident for needed changes in the treatment plan. Findings: During a review of the facility policy titled Change of Condition Notification, dated 4/1/15 indicated that the facility will promptly inform the resident, consult with the residents Attending Physician, and notify the resident's legal representative or an interested family member, if known, when the resident endures a significant change in their condition caused by, but not limited to: an accident, a significant change in the residents physical, mental, or psychosocial status; and or a significant change in treatment. A change of condition related to attending physician notification is defined as when the attending physician must be notified when any sudden and marked changes in the resident's condition which is manifested by signs and symptoms different than usual.During a review of Resident 1's medical record indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses that included sepsis (a serious condition in which the body responds improperly to an infection), pneumonia (lung inflammation caused by an infection), and end stage renal disease (the kidneys no longer work as they should to meet the needs of one's body).During a concurrent interview and record review on 12/23/25 at 2:02 pm with the Director of Staff Development (DSD), the DSD confirmed from 11/30/25 to 12/8/25 Certified Nursing Assistants (CNAs) documented that Resident 1 was having loose stools every day. The DSD confirmed that CNAs should report loose stools to the nurse and that after three days of loose stools the nurse should contact the doctor. During a concurrent interview and record review on 12/23/25 at 3:07 pm with the Director of Nursing (DON), the DON confirmed that Resident 1 was given a stool soften on 12/4/25, 12/5/25, and 12/6/25 even though it was documented that Resident 1 had been having loose stools since 11/30/25. The DON stated that the expectation for nurses is to review bowel elimination documentation and assess the resident before giving a stool softener. The DON confirmed that after three days of loose stools the doctor should be contacted and that the doctor was not contacted for Resident 1 until 12/8/25 after eight days of loose stools. During an interview on 12/23/25 at 3:19 pm with Licensed Nurse (LN) A, LN A stated that she typically does not go back and review CNA documentation pertaining to bowel elimination LN A relies on the CNAs to tell them if a resident is having loose stools or from other LNs during report. After three days of a Resident having loose stools LN A would notify the doctor. During an interview on 12/23/25 at 3:37 pm with LN B, LN B stated that if a resident was having loose stools for three days, they would contact the doctor. LN B does not always review bowel elimination documentation before giving stool softener medication to residents.During an interview on 12/23/25 at 3:57 pm with Resident 1, Resident 1 stated that nursing staff do not ask him about his bowel movements, and he feels that communication with staff about his condition has been poor.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to withhold (not give) a stool softener medication as directed by the physicians' orders for one of three sampled residents (Resident 1). This failure resulted in Resident 1 continuing to receive the medication despite experiencing diarrhea. Findings:During a review of Resident 1's medical record, indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses that included sepsis (a serious condition in which the body responds improperly to an infection), pneumonia (lung inflammation caused by an infection), and end stage renal disease (the kidneys no longer work as they should to meet the needs of one's body).During a review of Resident 1's physician order, dated 11/17/25, indicated a new order for Bisacodyl (a laxative) oral tablet to be given once every day. Additional directions indicated hold for loose stools. During a review of Resident 1's electronic medication administration record (MAR) for 12/2025, indicated that from 12/1/25 to 12/3/25 Bisacodyl was held due to loose stools. From 12/3/25 to 12/6/25 bisacodyl was given. On 12/7/25 Bisacodyl was refused by Resident 1. It was not until 12/8/25 once the physician was notified that the order for Bisacodyl was changed to every day as needed for Resident 1.During a concurrent interview and record review on 12/23/25 at 2:02 pm with the Director of Staff Development (DSD), the DSD confirmed from 11/30/25 through 12/8/25 Certified Nursing Assistants (CNAs) documented that Resident 1 was having loose stools every day. The DSD confirmed that CNAs should report loose stools to the nurse and that after three days of loose stools the nurse should contact the doctor. During a concurrent interview and record review on 12/23/25 at 3:07 pm with the Director of Nursing (DON), the DON confirmed that Resident 1 was given a stool soften on 12/4/25, 12/5/25, and 12/6/25 even though it was documented that Resident 1 had been having loose stools since 11/30/25. The DON stated that the expectation for nurses is to review bowel elimination documentation and assess the resident before giving a stool softener. The DON confirmed that after three days of loose stools the doctor should be contacted and that the doctor was not contacted for Resident 1 until 12/8/25 after eight days of loose stools. During a concurrent interview and record review on 12/23/25 at 2:30 pm with the Infection Control Preventionist (IP), the IP stated that if a resident is having loose stools, then medications that cause loose stools should not be given to the resident and after three days of loose stools the doctor should be contacted. The IP confirmed that Resident 1 was having loose stools from 11/30/25 through 12/8/25 and on 12/8/25 the doctor was finally contacted, and infectious testing was done. During a review of the facility policy titled Medication - Administration, dated 6/26/25 indicated all medications shall be administered by licensed nursing staff according to the physician orders.