STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055734	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ukiah Post Acute	1349 South Dora St. Ukiah, CA 95482

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide nursing services to one of three sampled residents (Resident 1), according to professional nursing standards of practice when:1. Licensed Nurse 1 (LN 1) clocked out for her meal period, leaving Resident 1 unattended by licensed nursing supervision, while she (Resident 1) was in uncontrolled pain, and performing a risky procedure, 2. LN 1 failed to recognize Resident 1's change in condition and notify a facility physician.3. LN 1 failed to notify Resident 1's facility physician, and family she was transferred to a General Acute Care Hospital (GACH) emergency department.4. LN 1 failed to report to the oncoming Licensed Nurse, the need to notify Resident 1's family that she had been transferred to the hospital emergency department during her shift.As a result, Resident 1 called 911 herself to obtain emergency medical services to assess her condition, and transfer her to a GACH, where she was admitted for emergency life-saving treatments. These findings had the potential to result in serious harm to Resident 1, up to and including death. A review of Resident 1's facility admission record (Facility demographic) indicated she was admitted to the facility on [DATE], with a primary diagnosis of Acute Post Hemorrhagic Anemia (a sudden incident of excessive bleeding causing a condition in which the blood cannot deliver enough oxygen to the body), Ulcerative (Chronic) Proctitis with Rectal Bleeding (a persistent condition of inflammation at the very end of the large intestine that causes tiny sores that swell and cause bleeding) and Gastro Intestinal Hemorrhage (bleeding in the digestive tract).A review of Resident 1's Nursing Care Plan initiated on 10/10/25 indicated Resident 1 was at risk for constipation (difficulty passing stools) related to reduced mobility and medication side effects. A nursing intervention listed under this focus area indicated, Monitor/Document Report to MD [Medical Doctor], as needed. This care plan indicated the signs and symptoms of complications related to constipation included, agitation .abdominal distention .vomiting . abdomen: tenderness .fecal compaction.During an interview on 12/10/25 at 1:32 p.m., LN 1 stated on 11/28/25, she was working the night shift as the Charge Nurse, and around 11 p.m., Resident 1 complained of abdominal pain and requested pain and bowel-care medication (medication to treat constipation) thinking she might need to have a bowel movement. LN 1 stated she administered Acetaminophen (an over-the-counter medication used to treat mild to moderate pain) and Milk of Magnesia (an antacid to relieve heartburn and indigestion, and saline laxative to treat occasional constipation). LN 1 stated Resident 1 was dissatisfied with the intervention and requested a suppository (a rectal medication), enema (a procedure in which liquid is introduced into the rectum to stimulate a bowel movement), and the performance of fecal disimpaction (a medical procedure in which a healthcare provider uses a gloved, lubricated finger to manually break up and remove a large, hardened mass of stool [fecal impaction] from the rectum) by LN 1. LN 1 stated she explained to Resident 1 that she could not fulfill her requests and asked to allow time for the medication to take effect. According to LN 1, Resident 1 replied that she would perform fecal disimpaction on herself and started to do it. LN 1 stated she left Resident 1, while she was performing this procedure, and clocked out for her meal period, without having another Licensed Nurse check on Resident 1 during her break. LN 1 stated that during her lunch period, a Certified Nursing Assistant (CNA) alerted her Resident 1 had blood on her fingers and hands. LN 1 stated she told the CNA that she was not surprised because Resident 1 has been doing fecal disimpaction on herself for about 30 minutes with her long fingernails. LN 1 stated the CNA told her (LN 1) Resident 1 was going to call 911 to get help, but by the time she clocked back from lunch and was about to check on Resident 1, the CNA told her Resident 1 had already called 911 herself. LN 1 stated emergency medical services arrived at the facility and took Resident 1 to the GACH. LN 1 then stated that she, totally dropped the ball on facility protocol, and did not notify Resident 1's family or attending physician that she had been transferred to a GACH by emergency services. LN 1 also admitted that she did not report to the next shift's charge nurse that Resident 1's family had not been notified of her emergency transfer to the hospital. A review of Resident 1's Medication Administration Record (MAR) for the month of November, 2025, indicated a documented pain level assessment of four out of ten (a pain scale from zero to ten, in which zero indicates no pain, and ten is the worst pain experienced during a person's lifetime), followed by an administration of two tablets of Acetaminophen 325 mg (mg = milligram; a unit of measure) to Resident 1 at 11:31 p.m. which resulted in ineffective, pain control as documented by LN 1. Resident 1's MAR also indicated LN 1 administered the medication Zofran (a prescription medication used to prevent nausea and vomiting) 4 mg tablet to Resident 1 at 11:39 p.m. The Zofran order indicated it was