STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055853	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redwood Cove Healthcare Center	1162 S 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to treat one resident (Resident 1) out of three sampled residents with dignity and respect when facility staff entered Resident 1's room without announcing themselves or being invited in.This failure caused Resident 1 to feel anxious and unsafe in his room.A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of Chronic Venous Hypertension (a condition characterized by high pressure inside the veins, most commonly in the legs) with ulcer (an open sore on the skin) of left lower extremity (leg) and Chronic Post Traumatic Stress Disorder (a mental health condition that can develop after experiencing a terrifying or dangerous event).A review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 6/20/25 indicated Resident 1 had a Brief Interview for Mental Status (BIMS, an assessment used to measure cognition (a person's ability to process information and understanding)) score of 14 which indicated Resident 1's cognition was intact.A review of Resident 1's Care Plan, dated 2/17/25, indicated Resident 1's risk for decreased psychosocial well-being and adjustment issues, emotional distress and ineffective coping skills. Resident 1's goals were to express or exhibit relief of pain after alternative comfort measures were administered. The staff were expected to implement interventions that included encouraging Resident 1 to express his emotions, help Resident 1 to identify triggers that prompt symptoms and to observe for signs and symptoms of distress.A review of Resident 1's Progress Notes dated 8/11/25 at 12:50 p.m., indicated the Director of Nursing (DON) spoke with Resident 1 regarding an incident in which Resident 1 yelled at a staff member for entering Resident 1's room without knocking. The DON indicated to Resident 1 the staff will make their presence known before entering his room to ensure comfort and avoid startling him.there will be instances where we will not wait for his approval to enter, particularly in emergencies or situations where he is unable to respond.A review of Resident 1's Progress Notes dated 8/11/25 at 2:27p.m., indicated Resident 1 was observed becoming visually and verbally upset that the Certified Nursing Assistant [CNA] did not wait to be welcomed into the room, despite the door being open. During an interview on 8/27/25 at 11:25 a.m., in the conference room, Resident 1 stated he spoke to the DON about his request to allow staff into his room at his discretion. Resident 1 stated the DON told him he would honor the request with understanding that in cases of emergency, the staff would not wait for an invitation to enter. Resident 1 stated he understood but the staff continued to walk in without knocking, announcing or being invited in. Resident 1 also statedthat because he occupied the bed farthest from the door, staff would often open the curtain that separated Resident 1 from his roommate without permission. Resident 1 further stated, They [the staff] have no sense of privacy. I could be using the commode. It gives me anxiety. I need to feel secure in my own room. I need my privacy.During an interview on 8/27/25 at 12:17 p.m., the Director of Staff Development (DSD) stated both nursing and CNAs receive Resident Rights education during the orientation process. Thereafter, it is presented quarterly to all staff providing direct care. The DSD stated she taught the correct way to enter a resident's room was to knock, while stating knock, knock out loud so the resident hears you. Specific requests such as waiting for an invitation to enter would be handed off during shift-to-shift report.During an interview on 8/27/25 at 12:34 p.m., the DON stated, We will cater to their [residents] wishes, as long as it is reasonable, or won't hurt themselves or others. The DON stated Resident 1's request was reasonable and understood Resident 1 needed his privacy.A review of facility policy titled Resident Rights, dated 2001, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence.be treated with respect, kindness, and dignity.