

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055853	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2025
NAME OF PROVIDER OR SUPPLIER Redwood Cove Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, interviews and record reviews, the facility failed to maintain an infection prevention and control program to provide a safe environment for all residents of the facility when the facility failed:1.implement and follow enhanced barrier precautions (EBP, an infection control intervention, primarily used in nursing homes, that involves the use of gowns and gloves during high-contact resident care activities to reduce the transmission of Multidrug-Resistant Organisms (MDRO)- microorganisms, primarily bacteria, that are resistant to one or more classes of antimicrobial agents) for Resident 7 and Resident 78, and 2. to review and revise, at least annually, the facility's infection prevention and control (IPC) policy and procedure (P&P).These failures increase the risk of infection, potentially leading to outbreaks (the occurrence of more cases of disease or health events than is normally expected in the facility, often appearing suddenly or in a cluster), that may cause severe health complications. Not reviewing IPC policies annually had the potential to hinder response to emerging threats and infection prevention.Findings:1. A review of Resident 7's baseline care plan, initiated 8/29/25, indicated resident 7 had wounds to his lumbar (lower back) and left buttocks areas.A review of Resident 78's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated resident admitted to the facility in 9/2025 with a colostomy (a surgical opening, called a stoma, created for waste to exit into a collection bag).During an interview on 09/23/2025 at 9:15 AM, the Resource Nurse (RN) verified residents who had a colostomy and/or open wounds should have an EBP signage posted outside their room to notify staff to wear proper personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) when providing high contact care with these residents. The RN stated it was important to ensure EBP was followed to lessen the risk of spreading infection in the facility. During a concurrent observation and interview on 09/23/2025 at 2:01 P.M., Resident 78 was noted to have a colostomy. Resident 78 stated staff did not wear a gown when changing her linens or during toileting hygiene.During an interview on 09/24/2025 at 5:23 PM, The Director of Nursing (DON) confirmed Resident 7 had an open wound and Resident 78 had a colostomy, both requiring EBP signage to alert staff to use appropriate PPE (gloves and gown) and follow protocols. The DON added, that failure to follow EBP could lead to infection outbreaks.During a concurrent observation and interview on 09/25/2025 at 9:45 AM, the interim Infection Preventionist (IP) was observed providing wound care to Resident 7 without wearing a gown. The IP acknowledged not following EBP and confirmed that gowns should be worn during high-contact care, including for residents with wounds or indwelling devices like colostomies. The IP stated this lapse could lead to cross-contamination and infection. She also confirmed there was no EBP signage inside or outside Resident 7's room.During a concurrent observation and interview on 09/25/2025 at 10:05 AM, The interim IP confirmed there was no EBP signage inside or outside Resident 78's room. IP stated staff should wear gloves and gowns when changing linens or providing toileting hygiene, and emphasized the importance of signage to remind staff to use proper PPE for residents with colostomies or open wounds.A review of the facility's P&P titled Enhanced Barrier Precautions, revised December 2024, indicated, . Enhanced barrier precautions apply when. a resident.has a wound or indwelling medical device. EBPs employ targeted gown and glove use .during high contact resident care activities. (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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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interviews and record reviews, the facility failed to designate at least one qualified infection preventionist (IP), for all residents of the facility, when the those performing the role of the IP had not completed specialized training or obtained certification in infection control and prevention. Lack of a qualified IP could lead to an increased risk of infections spreading among residents and staff. Findings:During an interview on 09/24/2025 at 5:23 PM, the Director of Nursing confirmed the facility did not have a designated certified IP for approximately one month. The DON stated he and the interim IP were currently assuming the IP position but neither of them were certified. The DON stated it was important to designate a certified IP at the facility to ensure proper infection control protocol was being followed. The DON stated not having a certified IP could result in increased infection rate at the facility.During an interview on 09/25/2025 at 9:45 a.m., the interim IP stated the facility did not have a designated certified IP onsite. She stated she was the interim IP but was still training as an IP and was not a certified IP at this time. The interim IP stated it was important to have a certified IP at the facility to ensure an effective infection control program. During an interview on 09/25/2025 at 3:25 p.m., the Minimum Data Set coordinator (MDSC) stated she was a certified IP however she clarified that her job was focused on being the MDSC not the IP. The MDSC denied that she organized, developed, or directed the facility's infection control program. The MDSC clarified she was not performing tasks for the IP role. She confirmed the facility did not have a qualified IP for some time now. The MDSC stated it was important to have a certified IP to ensure reduced risks of infection at the facility and improve residents' health and safety.A review of the facility's Job Description: Infection Control Nurse, dated 2/2024, indicated, The primary purpose of [the] job position is to plan, organize, develop, coordinate and direct [the facility's] infection control program and it's activities.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe and sanitary kitchen environment for all 63 residents of the facility, when the kitchen had cracked and broken floor tiles. This failure can increase the risk of trips and falls from the uneven surfaces and create an environment for molds and mildew growth. Findings: During an initial tour of the kitchen on 09/22/25 at 12:24 p.m., the kitchen had several cracked and broken floor tiles. Photos were taken to document the finding. During a concurrent review of photos of the kitchen floor and interview with the Dietary Manager (DM) on 09/22/25, at 12:36 a.m., the DM confirmed the kitchen had several cracked and broken floor tiles. A review of Title 42 of the Code of Federal Regulations section 483.90(i), Other Environmental Conditions, indicated: The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview and records review, the facility failed to have an effective pest control system for all 63 residents of the facility, when cockroaches were observed in the kitchen under the dish washing sink. This failure had the potential to cause food contamination and endanger the vulnerable residents of the facility. Findings: During the initial tour of the kitchen on 9/22/25 at 12:21 p.m. insects that looked like cockroaches were observed crawling under the dishwashing sink. A video was taken of the observation. During an interview on 09/22/2025 at 2:08 p.m., Unlicensed Staff A reported seeing a large cockroach in the hallway near the shower room the previous week. She also acknowledged being aware of cockroach activity in the kitchen. She also emphasized that it is the facility's responsibility to ensure the kitchen and overall environment remain free of cockroaches, noting that cockroaches carry diseases that could potentially make residents ill. During a concurrent observation and interview with the Dietary Manager (DM) on 09/22/2025 at 2:50 p.m., the DM confirmed observing multiple cockroaches beneath the kitchen sink, on the floor behind the pipes, and around the grease trap. The DM acknowledged the facility was aware of the cockroach infestation, noting that it had also been identified during the previous year. The DM expressed concern about the presence of cockroaches in the kitchen, stating that they are unsanitary and could contribute to foodborne illness (any illness resulting from eating contaminated/spoiled foods). She further acknowledged that the facility's efforts to eliminate the infestation had been ineffective, as evidenced by the continued presence of cockroaches in the kitchen. During a concurrent observation and interview with Kitchen Staff B on 09/22/2025 at 3:03 p.m., Kitchen Staff B confirmed seeing multiple crawling cockroaches underneath the dish washing sink. Kitchen Staff B stated this was a constant and daily occurrence. Kitchen Staff B stated whatever the facility was doing to eliminate the cockroaches in the kitchen was ineffective. During an interview on 09/22/2025 at 6:02 p.m., the Registered Dietitian (RD) stated that cockroaches in the kitchen are unacceptable due to the risk of disease transmission, which could further compromise residents' health. The RD noted the presence of cockroaches indicated the facility's pest control measures were ineffective and emphasized the need to adopt a new or alternative pest management approach to eliminate the infestation. During an interview on 09/23/2025 at 9:15 AM, the Resource Nurse (RN) stated the facility was aware of the cockroach problem. During an interview with the County of Mendocino Environmental Health Program Manager (PM) on 09/23/2025 at 11:22 a.m. the PM stated the facility was responsible to keep cockroaches out of the kitchen as part of their food permit (an official authorization from a government health department that allows a business or individual to handle, prepare, store, or sell food). The PM confirmed seeing cockroaches during her inspection earlier in the day. The PM added, it was concerning seeing cockroaches during the day, since cockroaches were nocturnal, which indicated there was severe cockroach infestation. During an interview on 09/23/2025 at 10:37 a.m., a representative from the pest control company that serves the facility, confirmed the facility had a severe infestation of a German variety of cockroach. She attributed the issue largely to poor kitchen sanitation. The representative further explained that, prior to this date, cockroach treatments were conducted only on an as-needed basis when scheduled by the facility, rather than the recommended frequency of service every seven to 10 days. The representative stated she had advised the administrator that while pest control treatments can help, maintaining a clean kitchen and addressing moisture and leaks are essential to preventing infestations. A review of the facility's policy titled, Pest control, revised 5/2008, indicated the facility will maintain an effective pest control program to ensure that the facility is kept free of insects and rodents.		

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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. Based on interviews and record reviews, the facility failed to ensure that one out of 16 sampled residents (Resident 10) was informed in advance of the risks and benefits associated with a proposed treatment, when an informed consent (a voluntary agreement to accept treatment or procedures after receiving education about the associated risks, benefits, and available alternatives) was not obtained prior to the facility administering Resident 10 medication for depression. This failure placed Resident 10 at risk of receiving medication she might have declined had she been fully informed, potentially compromising her right to make informed decisions about her care. Findings: A review of Resident 10's face sheet (front page of the chart that contains a summary of basic information about the resident), indicated she was admitted to the facility in March of 2023 with a diagnosis of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 10's order summary, for the month of September 2025, indicated on 8/10/25, Resident 10 was prescribed Trazadone HCl (a medication to treat depression) Oral Tablet 50 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount), to be given half a tablet by mouth every evening for Depression manifested by inability to sleep. During a concurrent interview and record review conducted on 9/25/25 at 3:35 p.m. with the facility's Resource Nurse (RN H), Resident 10's medical records were examined. RN H confirmed that the chart did not contain any informed consent documentation indicating that Resident 10 or her responsible party had been provided with information regarding the risks and benefits of Trazodone. A review of Title 42 of the Code of Federal Regulations section 483.10(c)(5), indicated residents have, The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interview and record review, the facility failed to provide one of 16 sampled residents (Resident 46) with the opportunity to exercise her right to make a choice when her room was changed without her consent. This failure resulted in Resident 46 feeling upset and as though she didn't have a choice. Findings: A review of Resident 46's admission record indicated she was admitted to the facility in May 2020 with diagnoses which included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 46's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 6/17/25, indicated Resident 46 had no memory impairment. During an interview on 9/23/25 at 1:54 p.m., Resident 46 stated she had to change rooms because the facility needed her room for a new admission. Resident 46 stated the change of her room upset her and she felt like she didn't have a choice. During an interview on 9/25/25 at 12:41 p.m. with the Director of Nursing (DON), the DON confirmed Resident 46 was moved to another room. A request was made to the DON to provide documentation regarding the reason for the room change and evidence the room change was discussed and agreed upon with the resident. The requested documents were not provided. During a review of the facility's policy and procedure (P&P) titled, Room Change/Roommate Assignment, dated 2001, indicated, .Resident room or roommate assignments may change if the facility deems it necessary. Resident preferences are taken into account when such changes are considered .During a review of the facility's P&P titled, Resident Self Determination and Participation, dated 2001, indicated, Our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. Residents are encouraged to make choices about aspects of their lives in the facility.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interviews and record reviews, the facility failed, for three out of 16 sampled residents (Residents 1, 7 and 9), to ensure a written summary of the baseline care plan (BCP, a document created within 48 hours of a resident's admission, outlining the initial care needed, focusing on basic needs and resident-specific information) was provided to the resident and or the responsible party (RP, a person who is designated in making decisions about health care and financial matters). This failure could compromise residents' safety, hinder effective communication, and could lead to adverse events, especially during the critical initial days of admission. Findings: A review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date of 8/21/25 with a diagnosis of muscle weakness and dysphagia (difficulty swallowing). A review of Resident 1's Baseline Care Plan-Person Centered Care Planning-V3.1 form, with an effective date of 8/21/25, did not indicate the BCP summary was provided to the resident or their RP. A review of Resident 7's face sheet indicated an admission date of 8/29/2025 with a diagnosis of muscle weakness and difficulty walking. A review of Resident 7's Baseline Care Plan-Person Centered Care Planning-V3.1 form, with an effective date of 8/29/25, did not indicate the BCP summary was provided to the resident or their RP. The form also indicated it was completed by facility staff on 9/2/25. A review of Resident 9's face sheet indicated an admission date of 8/21/25 with a diagnosis of hypothyroidism (underactive thyroid gland) and hyperlipidemia (high cholesterol). A review of Resident 9's Baseline Care Plan-Person Centered Care Planning-V3.1 form, with an effective date of 8/21/25 did not indicate the BCP summary was provided to the resident or their RP. During an interview on 09/24/2025 at 3:34 PM, the Director of Rehabilitation (DOR) stated she was one of the team members that fills out the Baseline Care Plan-Person Centered Care Planning-V3.1 form. The DOR stated it was important that the BCP is completed timely and added, not completing the BCP timely could result in staff miscommunication and delayed intervention for the resident's safety. During a concurrent interview and record review on 09/24/2025 at 3:37 PM, with the Director of Nursing (DON), the Baseline Care Plan-Person Centered Care Planning-V3.1 forms for Residents 1, 7, and 9 were reviewed. The DON stated it was important to complete the BCP within 48 hours of admission to establish support for residents as early as day 1, ensuring safe care was coordinated and provided to the residents. The DON stated not completing the BCP within 48 hours of admission could result in miscommunication and unsafe care. The DON stated, if the BCP was not done within 48 hours of admission and /or if the BCP summary was not provided to the resident or the RP, then it indicated the facility's BCP policy was not followed. The DON verified the BCP summary was not provided to Residents 1, 7, and 9 or their RPs. The DON also verified Resident 7's BCP was completed late, over 48 hours after their admission. A review of the facility's policy and procedure (P&P) titled Care Plans-Baseline, undated, indicated, . a baseline plan of care to meet the resident's immediate health and safety needs to be developed for each resident within 48 hours of admission. resident and or representative are provided a written summary of the baseline care plan. provision of the summary to the resident and or resident representative is documented in the medical record.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record facility failed to ensure its medication error rate was less than 5 percent (% a unit of measure) when there were two errors out of 33 medication administration opportunities for a 6.06% medication error rate. This failure decreased the facility's potential to safely administer medications per physician's orders and prevent the risk of adverse outcomes. Findings: During a concurrent observation and interview on 9/25/25 at 08:18 a.m. with Licensed Nurse E (LN E), LNE was observed giving Resident 1 Metoprolol Tartrate (a heart medication) 25 milligrams (mg, a unit of measurement) tablet, and Amiodarone (a medication to regulate the heart's rhythm) 100 mg tablet. LN E confirmed she gave Resident 1 both medications when Resident 1's systolic blood pressure (SBP, the maximum pressure the heart generates when it beats) was 122 millimeters of mercury (mmHg, a measurement of pressure) and the diastolic pressure (DBP, the minimum pressure the heart generates when it beats) was 72 mmHg. During a record review of Resident 1's Order Summary Report, dated 9/18/25, indicated, Metoprolol Tartrate oral tablet. Give 25 mg. do not give if diastolic blood pressure (DBP) less than 90 mmHg . notify MD [medical doctor], and Amiodarone give 100 mg . do not give if SBP less than 100 mm Hg . and notify MD. In an interview on 9/5/25 at 10:28 a.m. with the Director of Nursing (DON), the DON confirmed the medication order indicated to not give Resident 1 the medications when SBP was less than 100 mmHg. The DON acknowledged the administration of medication outside ordered parameters could lower the resident's blood pressure (BP) and potentially cause a hypotensive crisis, (a life-threatening condition where BP drops dangerously low). During a review of the facility's policy and procedure titled Preparation Guidelines Medication Administration-General Guidelines, dated May 2022 indicated, . Prior to administration of any medication. the physician's orders are checked for the correct dosage schedule. current directions .		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interviews and record reviews, the facility failed to ensure medications were stored safely for one out of 16 sampled residents (Resident 6), when Resident 6 was allowed to self-administer aspirin (ASA) and antacid tablets as well as keep the ASA and antacid tablets at her bedside with no assessment or physician's order. These failures put Resident 6 at risk for medication error and misuse. Findings: A review of Resident 6's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date in 12/2021 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD, lung disease, such as asthma or emphysema) and essential Hypertension (high blood pressure). A review of Resident 6's Physician Order Summary (POS, a healthcare professional's written instruction specifying the care, services, treatment and medications a patient should receive, active as of 9/24/25, the POS indicated an order for ASA 81 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) daily. There were no orders for antacid tablets or for self-administration of either medication. During a concurrent observation and interview on 09/23/2025 at 2:07 p.m., in Resident 6's room, ASA 325 mg was found in her bedside drawer and antacid tablets 1000 mg on her overbed table. Resident 6 stated she had no physician order for either medication, staff had not assessed her ability to self-administer the medications, and she had been using and storing them in her room for over a month without staff intervention. Resident 6 added, she took the ASA whenever she had a headache and the antacid when she had an upset stomach. During a concurrent interview and record review on 09/25/2025 at 3:52 PM, with the Director of Nursing (DON), Resident 6's POS was reviewed. The DON stated only residents with a completed assessment may self-administer medications or keep them at bedside. She confirmed Resident 6 had ASA 325 mg and antacid tablets at her bedside without such an assessment. The DON acknowledged this was not permitted, posed a risk for medication errors or misuse, and that the POS lacked orders for antacid tablets and for self-administration. She also confirmed the ASA order was for 81 mg, not 325 mg. A review of the facility's policy and procedure (P&P) titled Medication Labeling and Storage, undated, indicated, . the facility stores all medications and biologicals in locked compartments. the nursing staff is responsible for maintaining medication storage. A review of the facility's P&P titled Administering Medications, undated, indicated, . medications are administered in accordance with prescriber's order.		