

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: 056215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Northbrook Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 64 Northbrook Way Willits, CA 95490	
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review the facility failed to ensure that food was prepared by methods that preserved nutrition and palatability when three residents (Resident 20, Resident 26, Resident 30) out of 38 residents received meals that were flavorless, difficult to chew and overcooked. This failure decreased the facility's potential to serve food to residents with nutritive content and decreased the residents' potential to maintain or increase their meal intake with food served by the kitchen. Findings: During a concurrent interview and observation in Resident 26's room on 1/28/26 at 8:30 a.m., Resident 26 complained about the potatoes he was served for breakfast. The cubed potatoes noted on his plate were pale in color. Resident 26 stated the potatoes were too difficult for him to chew because the potatoes were still raw in the center. Resident 26 was observed trying to cut one of the cubed potatoes with a fork and was noted to have difficulty doing so. Resident 26 stated the potatoes served in this fashion were usually hard and were inedible. Resident 26 further stated the oatmeal served to him was always tasteless and he never ate it. During an interview in Resident 26's room on 1/28/26 at 8:56 a.m., the Certified Dietary Manager (CDM) confirmed the potatoes on Resident 26's plate were hard, making it difficult for Resident 26 to chew. The CDM reviewed Resident 26's tray ticket and acknowledged Resident 26 had an ordered texture of easy to chew for his diet. During an observation of the facility kitchen on 1/28/26 at 10:21 a.m. two metal steam table pans were observed on the stovetop with aluminum foil secured on top. The CDM stated [NAME] 1 placed broccoli and carrots in each pan with water to boil on the stove just before leaving for his break. During an observation in the kitchen on 1/28/26 at 11:18 a.m., [NAME] 1 placed frozen, filleted pieces of Tilapia fish on heated sheet pans without added seasoning. During an observation on 1/28/26 at 11:25 a.m., [NAME] 1 placed the frozen fish into the oven. [NAME] 1 then opened a large can of diced tomatoes and placed the diced tomatoes in a pot on the stove. He then added an unmeasured amount of dried diced onion, garlic powder, salt and oregano to the tomatoes. [NAME] 1 stated he was making the Italiano sauce for the fish and chicken which was a substitute protein for residents who did not like fish. The fish was removed from the oven at 11:45 a.m. During an observation on 1/28/26 at 11:50 a.m., the broccoli and carrots were removed from the stovetop and drained. The total cooking time on the stovetop was 1.5 hours. [NAME] 1 was not observed adding any seasoning to the carrots. [NAME] 1 added an unmeasured amount of bottled chopped garlic to the broccoli. During an observation in the kitchen trayline plating started on 1/28/26 at 12:30 p.m., [NAME] 1 was observed placing a piece of unseasoned Tilapia on a plate and smothered the fish with an unmeasured amount of Italiano sauce. The [NAME] repeated this process for the substitute chicken. [NAME] 1 was not observed to taste any part of the entree to ensure it was palatable. During an observation in the Station 1 hallway on 1/28/26 at 2 p.m., a food cart that had collected trays after residents completed their lunch was observed to have trays with half eaten or whole pieces of untouched Tilapia fish. During a concurrent observation and interview on 1/29/26 at 8:25 a.m., Resident 20 stated, Breakfast was disgusting. It didn't look appetizing. Resident 20 was observed to have a grilled cheese sandwich given to her as a substitute. The sandwich had a few bites taken from it. Resident 20 stated she was no longer hungry. A review of the facility's recipes indicated the following:- Broccoli with garlic, dated 2025, indicated, Boil or steam broccoli. (Approximate time for (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	steamer is 10 min/pan).- Fish Italiano, dated 2025, indicated, Wash and rinse onions under cold running water. Saute onions in margarine until transparent.Place fish on top of the onions, sprinkle lightly with salt, pepper, and garlic powder. Place tomatoes on top of fish, sprinkle with basil, oregano, and parsley. Cover and bake at 375 F [Fahrenheit-a measurement of heat] for 15-25 minutes. Spoon juice over the fish and serve. Internal temperature must register at least 145 F for 15 seconds. Serve on trayline at the recommended temperature of 160 F- 180 F.A review of the facility's policy titled Food Preparation, dated 2023, indicated, Food shall be prepared by methods that conserve nutritive value, flavor and appearance.The facility will use approved recipes, standardized to meet the resident census.Recipes are specific as to portion yield, method of preparation, quantities of ingredients, and time.guidelines.A review of the facility's document titled Season Your Food Without Salt, dated 2025, indicated some herbs and spices may be used to season by taste. Further review of this document indicated, The flavor of herbs and spices varies greatly from brand to brand and by freshness.A review of an article published by PubMed titled Cooking at home to retain nutritional quality and minimize nutrient losses: A focus on vegetables, potatoes and pulses, dated 10/26/22, indicated, Cooking methods that expose plant foods to high temperatures and/or water for long periods of time (e.g. boiling) may be the most detrimental to nutrient content, whereas other cooking methods such as steaming or microwaving may help to retain nutrients.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure that food was stored, prepared and served safely in accordance with professional standards of food service when: Clean plastic cups were stored in soiled, heavily scratched plastic racks and food crumbs were observed under a layer of dirty plastic netting which clean eating utensils were stored on top of in a utensil tray; and, The front of the facility stove was stained with old grease drippings while the stovetop was encrusted with hardened black residue; and, Cook 1 failed to maintain proper hand hygiene during meal prep and trayline when he repeatedly contaminated his gloves by touching his personal clothing and other kitchen items before handling food products; and, Refrigerated items found with no use by date. These failures posed the risk for food borne illness for 38 residents for a census of 38 residents that resided in the facility and consumed food prepared in the kitchen. Findings: 1. During a concurrent observation and interview in the facility kitchen on 1/27/26 at 9:56 a.m., clean plastic cups were noted to be stored lip side down in soiled, heavily scratched racks. The Certified Dietary Manager (CDM) confirmed the racks were visibly scratched and soiled. During a concurrent observation and interview in the facility kitchen on 1/28/26 at 10:41 a.m., clean dining ware was observed to be stored in a utensil tray containing accumulated food debris under a dirty protective netting. The CDM confirmed this posed a risk for contamination of the clean utensils. The CDM removed the utensils from the tray and washed all stored utensils and the utensil tray. A review of the Food and Drug Administration (FDA) Food Code 2022, 4-601.11 (A) indicated, Equipment Food-Contact Surfaces and Utensils shall be clean to sight and touch. 2. During a concurrent observation and interview in the facility kitchen on 1/27/26 at 9:50 a.m., the CDM confirmed the stovetop had encrusted debris in between and in burners, and the front of the stove was soiled with old grease drippings. The CDM stated the stove was cleaned daily with a scheduled weekly deep clean. The CDM stated, The equipment must be clean and ready to use. The CDM further stated she developed the cleaning and deep cleaning logs. A review of the facility's policy titled Sanitation, dated 2023, indicated, The Food and Nutrition Services Department shall have equipment necessary for the proper preparation of food. All equipment shall be maintained as necessary. A review of the FDA Food Code 2022, 4-602.12(A) Cooking and Baking Equipment indicated, the food contact surfaces of cooking and baking equipment shall be cleaned at least every 24 hours. A review of the FDA Food Code 2022, 4-602.13 indicated, the non-contact food surfaces shall be cleaned at a frequency necessary to preclude accumulation of soil residues. 3. During an observation in the facility kitchen on 1/28/26, at 11:25 a.m., [NAME] 1 was observed to pull up his pants with gloved hands, retrieve a scale from shelf, and did not wash his hands between changing his gloves and touching food. During an observation on 1/28/26 at 11:30 a.m., [NAME] 1 was looking at a chart that hung on the kitchen wall. When the chart fell off the wall, [NAME] 1 picked up the chart with gloved hands, replaced the chart on the wall, retrieved a cutting board, and began to cut butter without changing gloves and washing his hands. During an observation on 1/28/26 at 11:35 a.m., [NAME] 1 pulled up his pants, checked and touched his watch. [NAME] 1 then immediately continued to stir meat on the stove and made sauce for the risotto without changing his gloves and washing his hands. During an observation on 1/28/26 at 11:50 a.m., [NAME] 1 pulled up his pants and continued to make sauce for the lunch entree and removed vegetables from the stovetop without changing gloves and washing his hands. During an observation on 1/28/26 at 12:17 a.m., [NAME] 1 pulled down his shirt, pulled up his pants and continued to puree carrots in the food processor without changing gloves and washing his hands. During an observation on 1/28/26 at 1:10 p.m., [NAME] 1 pulled up his pants while plating residents' plates on trayline without changing his gloves and washing his hands. During an observation on 1/28/26 at 1:20 p.m., [NAME] 1 pulled up his pants while plating residents' plates on trayline without changing his gloves and washing his hands. A review of the facility's policy titled Inservice: (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Personal Hygiene, undated, indicated, Hands are a major source of food contamination.wash hands.prior to wearing gloves and.changing tasks.A review of the FDA Food Code 2022, 2-301.14(F)(H)(I), Personal Cleanliness indicated, Food employees shall clean their hands. immediately before engaging in food preparation.and.during food preparation as often as necessary to remove.contamination and to prevent cross contamination.and before donning gloves to initiate a task that involves working with food and.after engaging in other activities that contaminate the hands.4. During a concurrent observation and interview in the kitchen on 1/27/26, this surveyor observed a carton of soy milk with an open date of 1/19/26 and a bottle of vegetable juice with an open date of 1/5/26. Neither the carton of soy milk nor the bottle of vegetable juice had a use by date or expiration date written on it. The CDM confirmed these needed to be discarded, as both had expired.A review of the facility's policy titled Labeling and Dating of Foods, date 2023, indicated, Foods that are commercially processed, ready to eat and intended to be stored cold greater than 24 hours will be marked with a 'use by' date. The 'use by' date will incorporate the open date for TCS (Time, Temperature Control for Safety) foods as defined by the Federal Food Code.Once daily, the PM [evening] cook and/or the PM Diet Aide will be responsible to inspect the refrigerators and discard perishable foods that are TCS in order to ensure food safety.A review of the FDA Food Code 2022, 3-501.17 indicated, .refrigerated, ready to eat, time/temperature control for safety food.held for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises. or discarded when held at a temperature of 5 C [Celsius- a measurement of temperature] (41 F [Fahrenheit- a measurement of temperature]) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.		

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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 and interview, the facility failed to maintain an environment free of pests for 38 residents for a census of 38 when two flies were observed in the kitchen during food preparation. This failure decreased the facility's potential to prevent foodborne illnesses among residents. Findings: During a concurrent observation and interview in the kitchen on 1/28/26 at 10:55 a.m., two flies were observed flying around the area where lunch was being prepared. The Certified Dietary Manager (CDM) confirmed the presence of flies in the kitchen. The CDM stated the flies may have come in with someone when they entered the building from the outside. There was no electronic air curtain noted upon entry to the facility. A review of the facility's policy titled Pest Control, dated February 2025, indicated, It is the policy of this facility to utilize pesticides in a safe and efficient manner to control pests. The following are guidelines for pest prevention. All storage and food preparation areas are to be kept clean. This includes equipment. A review of the FDA 2022 Food Code 6-501.111(A)(B) indicated, the premises shall be maintained free of insects. the presence of insects. shall be controlled to eliminate their presence on the premises by routinely inspecting shipments of food and supplies. routinely inspecting the premises for evidence of pests.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure food preferences were honored for four residents (Resident 10, Resident 30, Resident 41, Resident 26) of 38 sampled residents when the residents were served meals which contained food they disliked. This failure decreased the facility's potential to serve food that met residents' nutritional needs. Findings: During a concurrent observation and interview in the facility dining room on 1/27/26 at 12:31 p.m., Resident 10 and Resident 41 were eating their lunches. This surveyor observed both residents' plates contained untouched peas. Resident 10 stated she did not like peas and Resident 41 stated she had never liked peas and was confused as to why they were placed on her tray. A review of their meal tray tickets indicated both Resident 10 and Resident 41 disliked peas. During a concurrent observation and interview on 1/27/26 at 1:09 p.m., Resident 30 was eating lunch in her room. Resident 30 stated, I will not eat the peas they served for lunch today because I like my vegetables cooked al [NAME] and these peas are too mushy. This is how the vegetables are usually served. Resident 30 also stated she was intolerant of lactose (a natural sugar found in dairy products) had a problem when the kitchen served her scrambled eggs made with milk for breakfast in the past. Resident 30 stated she became sick and had diarrhea from the eggs. A review of Resident 30's meal tray ticket indicated she had a lactose allergy, disliked milk, milk products and refined sugar and that she preferred .AI [NAME] Broccoli & Cauliflower when on the menu. During a concurrent observation and interview in Resident 26's room on 1/28/26 at 8:43 a.m., Resident 26 had only eaten his scrambled eggs the scrambled eggs on his breakfast tray. Resident 26 stated his oatmeal was tasteless and he could not chew his potatoes. He requested more scrambled eggs and toast from the kitchen because he was still hungry. The kitchen served Resident 26 one fried egg and one piece of dried toast without butter. Resident 26 was angry and asked to speak with the Administrator. During a concurrent observation and interview on 1/28/26 at 1:00 p.m., Resident 30's lunch tray contained a cherry square made with cream cheese and canned cherries on a graham cracker crust. Resident 30 stated it was too sweet for her. During an interview on 1/28/26 at 4:10 p.m., the Certified Dietary Manager (CDM) stated the kitchen referred to the dislike list when printing out resident tray tickets, which was updated quarterly or sooner if needed. The CMS confirmed the Cherry N' Cream Squares recipe called for powdered sugar and cream cheese, which were foods that Resident 30 did not like and cannot eat due to her lactose intolerance. The CDM stated Resident 30 was supposed to be served applesauce with cinnamon in place of the dessert served on the 1/28/26 lunch tray. The CDM further stated she was made aware that peas were served to residents that disliked them. During a concurrent observation and interview on 1/29/26 at 12:30 p.m., Resident 30's meal tray contained turkey, roasted potatoes, and green beans. Resident 30 stated she would not eat the green beans on her plate because they were overcooked and mushy. The resident took one of her chopsticks and stuck it in the green beans and it appeared mushy. During a concurrent observation and interview in Resident 30's room on 1/29/26 at 12:57 p.m., (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 30 stated she had received a piece of pie for dessert when she had asked that no food made with refined sugars be served to her. This surveyor observed a piece of apple pie on Resident 30's tray. A review of Resident 30's meal tray ticket indicated she disliked refined sugar. Resident 30 stated she will not eat it because it is too sweet for her. A review of the facility's policy titled Food Preferences, dated 2023, indicated, Resident's food preferences will be adhered to within reason. Substitutes for all foods disliked will be given from appropriate food group.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement care plans for two residents (Resident 20, Resident 21) of four sampled residents when Licensed Nurses (LN) did not: Initiate a care plan for Resident 20's need for oxygen therapy; and, Implement interventions indicated in Resident 21's care plan regarding the risk of skin impairment. These failures decreased the facility's potential to communicate Resident 20's care needs regarding oxygen therapy among facility staff and resulted in Resident 21 sustaining a wound to her left lateral (a side of the body positioned away from midline) upper calf. Findings: 1. A review of Resident 20's admission record indicated admission to the facility on 1/1/26 with a diagnosis of Heart Failure (a chronic disease where the heart cannot pump enough blood to meet the body's needs, often causing fluid buildup in the lungs or body). A review of Resident 20's physician orders dated 1/1/26, indicated, O2 [oxygen] 1 LPM [Liters per minute-indicates how much oxygen will be delivered per minute] via NC [nasal cannula-a flexible device used to deliver oxygen through the nose]. A review of Resident 20's MDS (Minimum Data Set- a federally mandated assessment tool) dated 1/2/26, indicated Resident 20 was receiving oxygen therapy upon admission and while a resident in the facility. During an observation on 1/27/26 at 11:18 a.m., Resident 20 was observed with oxygen being administered via a nasal cannula at 1 LPM. A review of Resident 20's care plans was conducted on 1/28/26 and found Resident 20's care plan regarding a need for oxygen therapy had been initiated on 1/27/26, 26 days after admission. During an interview on 1/29/26 at 2:27 p.m., the Director of Nursing (DON) confirmed a care plan for Resident 20's oxygen therapy had not been initiated until 1/27/26. The DON stated the oxygen care plan should have been developed upon admission. The DON further stated care plans were important because they drive care for the residents. 2. A review of Resident 21's admission record indicated Resident 21 was admitted to the facility on [DATE] with Chronic Atrial Fibrillation (a long term, irregular and often rapid heart rhythm that can lead to blood clots, stroke or heart failure). A review of Resident 21's care plan, dated 8/12/22, indicated t Resident 21 was at risk for skin impairment due to her fragile skin and blood thinner use. The nursing staff were expected to pad the edges of Resident 21's bedside table and pad the wheelchair armrests to assist Resident 21's to meet her goal of not having any complications. A review of Resident 21's physician orders, dated 7/16/23, indicated Resident 21 was to wear compression stockings 15-25 mmHg [millimeters of mercury-a unit of pressure. A range of 15-25 indicates a medium to firm medical grade compression designed to provide therapeutic, graduated pressure that improves blood flow, reduce swelling, and manages venous conditions]. A revision to Resident 21's care plan regarding a risk for skin impairment was made on 9/18/23 and indicated nursing staff were expected to apply compression stockings to BLE [Bilateral lower extremities] in the AM [morning] and remove [them] at HS [at bedtime]. During a concurrent observation and interview on 1/29/26 at 8:56 a.m., in Resident 21's room, Resident 21 was dressed in slacks and seated in her wheelchair. Licensed Nurse 1 (LN 1) attempted to pull up Resident 21's left pant leg to assess a resolved blister. Resident 21 told LN 1 her left leg hurt but LN 1 was unable to assess Resident 21's leg due to the pain caused by pulling up her pant leg. LN 1 stated she would have the Wound Nurse (WN) assess Resident 21's leg. During an interview on 1/29/26 at 10:18 a.m., the WN stated Resident 21's blister to the left shin had resolved; however, a new wound had developed to Resident 21's left lateral, upper leg. The WN stated Resident 21's wound lined up perfectly to the leg rest pegs on her wheelchair. During a concurrent observation and interview on 1/29/26 at 10:25 a.m., LN 1 confirmed Resident 21 had not been wearing compression stockings as ordered and care planned. In addition, LN 1 observed and acknowledged Resident 21's bedside table had not been padded nor had Resident 21's armrest area and the rest pegs for her legs been padded on her wheelchair. A review of Resident 21's Skin Issues assessment, dated 1/29/26, (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident 21's new wound on her left leg was acquired at the facility and measured 5 centimeters (cm- a unit of measure) in length, 2.5 cm in width, and 0 cm in depth. The exudate (fluid discharged from the wound) was described as sanguinous (containing blood) in a light amount.A review of facility policy titled Care Planning, dated 11/19, indicated, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident.A comprehensive care plan is developed within seven (7) days of completion of Resident Minimum Data Set (MDS). Revision or updating of the care plan will occur with quarterly, annually, upon significant changes of condition, or as requested by resident/resident representative or as deemed necessary by IDT.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one resident (Resident 3) of four sampled residents was properly groomed and had her call light within reach when Resident 3 was observed to have uncombed hair, dirty fingernails, and fecal matter (bowel movement) on her pillowcase, sheets and bedside table, and had no way to call for assistance. This deficiency decreased the facility's potential to ensure Resident 3 received personal care to maintain adequate hygiene. Findings: A review of Resident 3's admission record indicated admission on [DATE] with diagnoses of esophageal obstruction (blockage of the tube leading from the throat to the stomach), need for assistance with personal care, muscle weakness, and repeated falls. A review of Resident 3's care plan, initiated on 10/1/25, indicated Resident 3 was at risk for falls. Staff were expected to Be sure the call light is within reach and encourage to use it to call for assistance as needed to decrease her risk of falling. A review of Resident 3's care plan initiated on 10/1/25, indicated Resident 3 was at risk for a self-care deficient to carry out Activities of Daily Living (ADL- fundamental, routine self-care tasks necessary for independent living such as bathing, dressing, and toileting) Staff were expected to Encourage to use bell to call for assistance to decrease her risk of self-care decline. During an observation in Resident 3's room on 1/28/2026 at 10:30 a.m., Resident 3 was scrunched down in her bed with her shirt above her breasts with nothing else to cover her breasts. A dark thick brown substance was noted on her pillowcase and bedside table. The sheets on the far side of her bed had large brown streaks. Resident 3's hair was uncombed and all of her fingernails were long and had brown debris underneath the nails. Resident 3's call light was on the floor out of her reach. During a concurrent observation and interview in Resident 3's room on 1/28/26 at 10:32 a.m., Certified Nurse Assistant 1 (CNA 1) verified Resident 3 looked unkempt and her linens were dirty. CNA 1 stated she did not know what the brown substance on Resident 3's pillowcase, sheets, and bedside table were. CNA 1 acknowledged Resident 3 could not reach her call light because it was on the floor. During a concurrent observation and interview in Resident 3's room on 1/28/2026 at 10:35 a.m., CNA 2 stated she had left the room to get gloves. CNA 2 stated Resident 3 had slid down her bed and was scrunched down. CNA 2 stated the thick brown substance on Resident 3's pillowcase and bedside table was bowel movement (BM-fecal matter). CNA 2 stated the brown streaks on Resident 3's sheets were also BM. During a concurrent observation and interview in Resident 3's room on 1/29/2026 at 2:22 p.m., Resident 3 was lying in her bed. When Resident 3 was asked if she could reach her call light if she needed assistance, Resident 3 stated, I don't know where it is. This surveyor observed Resident 3's call light was looped over the drawer of her bedside table and out of reach. When Resident 3 was asked how she let staff know when she needed assistance, Resident 3 stated, I call for help. During a concurrent observation and interview in Resident 3's room on 1/29/2026 at 2:25 p.m., CNA 3 verified Resident 3's call light was out of her reach. CNA 3 verified Resident 3's fingernails were long, some were jagged, and she had what appeared to be food under her fingernails. CNA 3 stated CNAs conducted nail care unless the resident had diabetes. CNA 3 stated Resident 3 liked to eat with her hands, and her fingernails got dirty from her food. During a concurrent observation and interview in Resident 3's room on 1/29/2026 at 2:38 p.m. the Infection Prevention Nurse (IP) verified Resident 3 had debris under her fingernails and that some of the nails were jagged. When IP was asked if BM on Resident 3's tray table posed an infection control risk, she stated, Yes it does. During an interview on 1/30/26 at 10:15 a.m., the IP stated if residents who were dependent on staff could not get help when they needed it and their call light was out of reach, then they had an increased risk of falling while trying to access the call light. During a concurrent observation and interview in Resident 3's room on 1/30/26 at 11:18 a.m., Resident 3 was in her bed eating a piece of cake with her hands. Resident 3's call light was draped over the drawer on the bedside table out of her reach. When Resident 3 was asked if she knew where her call light was, she (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Northbrook Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 64 Northbrook Way Willits, CA 95490	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responded, I have no idea. When Resident 3 was asked if she used her call light when she knew where it was, she stated, Yes.A review of the facility's policy titled, ADL Services revised October 2016, indicated, Residents who are unable to carry out activities of daily living (ADL) will receive necessary services, on a daily and on as needed basis, to maintain.grooming.A review of the facility's policy titled, Call Light/Bell revised January 2019, indicated, Place the call device within the resident's reach before leaving the room.		

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory equipment was clean and in a usable state for one resident (Resident 20) out of four sampled residents when in Resident 20's oxygen concentrator had visible dust and debris in the vents. This failure decreased the facility's potential to prevent bacteria and debris from directly entering Resident 20's lungs, placing her at risk for infection. Findings: A review of Resident 20's admission record indicated Resident 20 was admitted to the facility on [DATE] with a diagnosis of Heart Failure (a chronic disease where the heart cannot pump enough blood to meet the body's needs, often causing fluid buildup in the lungs or body). A review of Resident 20's physician orders dated 1/1/26, indicated, O2 [oxygen] 1 LPM [Liters per minute-indicates how much oxygen will be delivered per minute] via NC [nasal cannula-a flexible device used to deliver oxygen through the nose]. A review of Resident 20's MDS (Minimum Data Set- a federally mandated assessment tool) dated 1/2/26, indicated Resident 20 was receiving oxygen therapy upon admission and while a resident in the facility. During an observation on 1/27/26 at 11:18 a.m., the outside vent on Resident 20 oxygen concentrator (a medical device that pulls air from the surrounding environment, filters out impurities and delivers medical-grade oxygen to residents with a respiratory condition) had dust buildup. During a concurrent observation and interview on 1/27/26 at 11:45 a.m., the Director of Nursing (DON), Infection Preventionist (IP) and the Maintenance Supervisor (MNS) confirmed there was dust built up on Resident 20's oxygen concentrator's vent. The compartment holding the internal filter was also observed to have dust buildup. The IP confirmed the dust build up was not good for Resident 20 and stated she was surprised to see how much dust had accumulated. The MNS stated he performed weekly checks on each oxygen concentrator in use, and blows out the dust with a compressed air canister. The MNS stated the facility owns all the oxygen concentrators. The MNS further stated he was responsible for cleaning the oxygen concentrators of all debris in addition to changing the filters. During an interview on 1/30/26 at 10:10 a.m., the IP stated an oxygen concentrator with dust buildup would be unhealthy for Resident 20 because the dust and debris which had accumulated in the vents could push the dust and other debris into Resident 20's lungs, placing Resident 20 at risk of developing a lung infection such as pneumonia or bronchitis. A review of the oxygen concentrator instruction guide, undated, indicated, the air filter. should be cleaned at least once a week. Clean the exterior cabinet by using a damp cloth or sponge with a mild household cleaner and wipe it dry. A review of the facility's policy titled Oxygen Therapy, dated January 2019 indicated, It is the policy of this facility to administer oxygen in a safe manner.		