STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056274	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Bluff Health Care Center	555 Luther Road Red Bluff, CA 96080

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents who were incontinent (involuntary loss of control) of bladder were assessed and provided appropriate treatment and services to maintain or improve continence to the extent possible for one of five sampled residents (Residents 1) when:1. Resident 1 did not receive a bowel and bladder assessment as needed (PRN).2. The Interdisciplinary Team (IDT, a group of healthcare disciplines that develop plans of care) did not re-evaluate Resident 1's incontinent status after changes in urinary status and update care plan as indicated.These failures had the potential to contribute to residents' decline or lack of improvement in urinary continence and or loss of bladder control and function.Findings:1. A review of the facility's policy titled, Bowel and Bladder Management Program, dated 10/21/2010, indicated Purpose to ensure that a resident who is incontinent of bowel and bladder receives the necessary care and treatment. 2. A bowel and bladder assessment form shall be completed on all residents with identified incontinence problems within 14 days of admission and PRN. 8. The IDT will review residents' incontinence status on admission and re-evaluate at least quarterly using the RAI-RAP guidelines. 9. Licensed Nurses and/or IDT will update care plans when indicated by a change in status.A review of Resident 1's clinical record indicated he was admitted to the facility on [DATE] with diagnoses that included depression, personality disorder (mental health condition where a person's way of thinking, feeling and behaving is very different from what is considered typical and these patterns are long lasting and hard to change) and anxiety.A review of Resident 1's Urinary care plan with a date initiated 2/24/26, indicated Resident 1 had an indwelling urinary catheter (a tube inserted into the bladder to drain urine), and urinary retention related to neurogenic bladder (nerves that tell the bladder when to hold urine and when to empty are not working properly causing trouble controlling urination or fully emptying their bladder). A review of Resident 1's admission Minimum Data Set (MDS, a standardized resident assessment), dated 3/9/26, indicated Resident 1 was cognitively intact (able to think and reason). Section H Bowel and Bladder status indicated Resident 1 had an indwelling urinary catheter.A review of the bowel and bladder assessment, dated 3/4/26, indicated Resident 1 had an indwelling urinary catheter and was incontinent of bowel (cannot fully control their bowel movements). Resident 1 required assistance in getting to the toilet, managing clothing and cleaning self after toileting.A review of Resident 1's Physician Orders for March/April 2026, indicated no orders for the removal of the foley catheter.During a review of a Health Status note dated 2/24/26 at 8:35 pm, Resident 1 complained of abdominal pain and had bladder distention (bladder has become stretched or swollen because it is holding too much urine). The note indicated that Resident 1 had not been able to urinate after his urinary catheter was removed that morning. Resident 1's doctor (MD) was notified and gave orders (instructed) Resident 1's urinary catheter be reinserted. A review of Resident 1's physician orders dated 2/24/26, indicated, Insert 16-Fr [French, a universal measurement for diameter of medical tubes) Foley catheter [brand name of a urinary catheter].A record review of Resident 1's History and Physical (H&P), written by MD on 2/24/26, indicated a diagnosis of urinary retention (an inability to empty one's bladder completely).A record review of (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's Physician's Orders, dated 4/3/26, indicated to discontinue (stop) the 16-Fr urinary catheter with a start date of 4/9/26.A review of the physician order dated 4/3/26 indicated Flomax (a medication to help improve urine flow and reduce urinary retention), 0.4 milligrams (mg, a unit of measure), give one capsule by mouth at bedtime.During a review of a Health Status note dated 4/8/26 at 10:27 pm, indicated the Resident 1's urinary catheter was discontinued per the physician's order and that Resident 1 will be monitored to ensure he was able to urinate. A review of Resident 1's Bowel and Bladder assessments showed that no bowel and bladder assessments were done after the urinary catheter removed. During a review of a Health Status note dated 4/9/26 at 10:33 pm, documentation reflected that Resident 1 continued to state he was not able to use the urinal. During a review of a Health Status note dated 4/10/26 at 6:54 am, documentation reflected that Resident 1 has refused multiple times to go to the bathroom to be toileted. During a review of a Health Status note dated 4/11/26 at 9:12 am, documentation indicated that Resident 1 continued to state that he does not know how to use a urinal and that education was provided. During a review of a Health Status note dated 4/11/26 at 12:29 pm, documentation reflected that nursing staff were made aware that Resident 1 had not urinated since the morning. Upon nursing assessment, Resident 1's bladder felt full. The Director of Nursing (DON) was notified about what to do next. Then while getting ready to get Resident 1 to the bathroom, he urinated a large amount and the nurse determined that Resident 1's bladder felt less full. Resident 1 has expressed at that time, he wanted his urinary catheter put back in and his MD was notified, but gave no new orders. During a review of a Health Status note dated 4/12/26 at 9:29 am, documentation reflected that Resident 1 continued to state that he does not know how to use a urinal and was re-educated. During a review of a Health Status note dated 4/12/26 at 11:11 am, a Licensed Nurse (LN) was called into Resident 1's room by nursing staff. Resident 1 was yelling and complaining of not feeling well and not being able to urinate. This nurse palpated on the resident's bladder and resident started urinating. Asked resident if he felt any better. Resident 1 then stated he did not feel better and that he would like his catheter back. The nurse then suggested that Resident 1 should use the toilet and feel relaxed to be able to empty bladder completely. During a review of a health status note dated 4/17/26 at 7:28 pm, the LN was called into resident's rooms CNA staff was taking vitals and residents blood pressure was 78/42 and Resident 1's feet were noted to be at a 45-degree angle and head of bed was lowered. Resident 1 was then assisted up, head at a 90-degree angle and feet lowered and vital signs went up 110/60, and Resident 1 stated that he felt better. Resident 1 stated that his mouth felt dry. MD was notified at approximately 5:20 pm and MD stated that he had seen Resident 1 earlier in the day and Resident 1 stated to him that he also felt unwell and that he was concerned of feeling he had a full blader. MD explained solutions to Resident 1 who cut him off and stated that every time he does something for him it never works and makes him feel worse. Resident 1 refused MDs help. Resident was then asked if he would like to receive assistance from MD to which he stated (NO LEAVE ME ALONE). A review of a health status note dated 4/17/26 at 9:56 pm, Resident 1 being monitored due to behaviors, resident has been making sad statements that he wants to die. Resident 1 refused all medications from this LN, stating that taking his medication will make him sick. Resident 1 verbalized not feeling well but does not want help from this LN or MD here. Resident 1 verbalized not wanting to go to hospital either stating I don't trust them. A review of a health status note dated 4/18/26 at 12:34 pm, Resident 1 being monitored due to behaviors. Resident 1 has had no behavior, but is requesting to go to hospital, but has no reason for needing to go. He is in no distress, will continue to monitor. During a review of Resident 1's hospital records was transferred to an acute care hospital with an admit day of 4/19/26, Resident 1 was discharged 8 days later 4/27/26 with a final diagnosis of septic shock (a life-threatening condition that happens when a serious infection overwhelms the body and causes blood pressure to drop dangerously low). kidney injury caused by septic shock. Catheter associated urinary tract infection (bacterial infection develops in someone who has a urinary catheter in place or recently had one) on admission and uremic encephalopathy (severe kidney failure causing toxins to build up in the body, (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	affecting brain function and leading to confusion or decreased alertness). During an interview 5/29/26 at 11:48 am, Licensed Vocational Nurse (LVN)1 stated Resident 1 came to facility with a foley catheter then later had it removed. LVN 1 stated if a resident mentioned increased pain, had increased behaviors or feeling like he had a full bladder after urination, the process was to call the physician. LVN 1 stated the only way to know if there was still urine in the bladder was to do a straight catheter (tube inserted into bladder only long enough to drain bladder). LVN 1 stated a physician order for a urinalysis (laboratory testing for an infection) may be needed.During interview 5/29/26 at 12:51 pm, Certified Nursing Assistant (CNA), stated Resident 1 had a urinary catheter removed, and had hard time adjusting. CNA stated Resident 1 was not feeling well but physician talked to him within the week. CNA stated before Resident 1 was transferred to the hospital for evaluation he acted differently when he knocked over his juice, looked weaker and was not as active.During a phone interview 6/1/26 at 9:47 am, LVN 2 stated Resident 1 complained about difficulty in urinating. LVN 2 stated when Resident 1 was asleep and relaxed, he would urinate further stating she felt like maybe he was too tense while awake to be able to urinate.During a phone interview 6/4/26 at 12:15 pm, LVN 3 stated Resident 1 had a foley catheter that was discontinued. LVN 3 stated Resident 1 would complain that he couldn't urinate and that they were hurting. LVN 3 stated he called physician and received an order to place the urinary catheter back in. LVN 3 stated Resident 1 complained about his care and not being able to urinate.During concurrent interview record review on 6/9/26 at 11:07l am, Director of Nursing (DON), stated once the urinary catheter was discontinued a new bowel and bladder assessment would be expected to be done. DON confirmed there was no nursing documentation that nursing staff were monitoring or tracking how often he urinated once the catheter was removed. DON explained Resident 1 would hold his bladder until he fell asleep and then urinated due to being relaxed. Reviewed bowel and bladder elimination documentation DON confirmed Resident 1 was voiding (urinate) and not voiding. DON stated there were some clinical signs and other assessments that could have been done and a new care plan to address bladder retraining.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of five sampled residents (Resident 1), had a behavioral health evaluation and services to meet psychiatric behavioral needs.This had the potential for Resident 1 to be at risk for worsening psychiatric symptoms, decline in their physical, emotional, and psychosocial well-being and unmet mental health needs.Findings:A review of a facility policy titled Behavior Management and Documentation of Behaviors: dated 9/1/2008, indicated B. Implement Interventions to Alleviate Possible Causal Factors. 7. Identify the additional resources if residents do not respond to usual interventions and forward slash or medications through the interdisciplinary team process comma case managers etc. C. Evaluate Outcome of Non-Drug Interventions 8. Review residence behavior symptoms and response to medication during the IDT and more often if indicated. Document all assessments, interventions and outcomes in the medical record.A review of Resident 1's clinical record indicated he was admitted to the facility on [DATE] with diagnoses that included personality disorder (mental health condition where a person's way of thinking, feeling and behaving is very different from what is considered typical and these patterns are long lasting and hard to change), other specified depressive episodes and anxiety.A review of the admission Minimum Data Set (MDS, a standardized resident assessment), dated 3/9/26, indicated Resident 1 was cognitively intact (able to think and reason).A review of the preadmission screening and resident review (PASRR, identifies residents with serious mental illness) dated on 2/24/26 indicated Resident 1 triggered for a Level II assessment which helps determine placement and mental health specialized services. No documentation in record for the level II screening being completed.During a review of physician orders dated 2/24/26, indicated two separate orders for Resident 1, may have psychology and psychiatric consult with follow up and treatment as needed. There was no documentation found in the record of a referral for either consultation.A review of the care plan initiated 2/26/26 indicated Resident 1 has a behavior problem of frequent calling out, yelling at staff, frequent concerns that have been addressed refusal of care. Interventions: Administer medications as ordered, monitor/document for side effects and effectiveness, anticipate and meet the needs of the resident, caregivers to provide opportunity for positive interaction, attention, stop and talk with him as passing by, explain all procedures to the resident before starting and allow resident to adjust to changes, if reasonable, discuss the residents behavior, Explain/reinforce why behavior is inappropriate and or unacceptable for resident, minimize potential for residents disruptive behavior by offering tasks which divert attention such as activities, snacks, TV, fresh air, etcetera.A review of the care plan date initiated 2/26/26 indicated Resident 1 has a behavior problem in effective coping related to maladaptive (not helpful, effective or supportive of healthy functioning) thinking patterns. Interventions: Administer medications as ordered, Monitor/document for side effects and effectiveness, anticipate and meet the needs of the resident, assist the resident to develop more appropriate methods of coping and interacting, encourage positive self-reflection encourage the resident to express feelings appropriately, caregivers to provide opportunity for positive interaction, attention, stop and talk with him or her passing by, praise any indication of the resident's progress/improvement in behavior, the residents triggers for any subject that would cause him to see himself as a victim pain could be a punishment, repositioning (related to maladaptive feelings) encouragement could be seen as I'm not good enough, I'm a bad person the residents behavior is deescalated by non-accusation type statements.A review of the care plan date initiated 3/17/26 indicated Resident 1 has potential to be verbally aggressive to staff and fellow peers related to mental/emotional illness. Interventions: Administer medications as ordered, Monitor/ document for side effects and effectiveness, assess residents coping skills and support system, when resident becomes agitated intervene before agitation escalates get away from source of distress; engage (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	calmly in conversation if response is aggressive staff to walk calmly away and approach later.A review of Resident 1's physician order summary from admission on [DATE] through his discharge 4/18/26, indicated Resident 1 was prescribed:-Buspirone (to treat Generalized Anxiety Disorder (GAD) and relieve short-term anxiety symptoms) HCl 10 milligrams (mg) one tablet three times a day related to anxiety manifested by anxiousness, started 2/24/26.-Bupropion (to treat depression) HCl extended release 300 mg one tablet by mouth one time a day related to depressive disorder manifested by sad statements, started 2/24/26.-Duloxetine (to treat depression and/or anxiety) HCl 30 mg one capsule one time a day related to depression manifested by pain, started 2/25/26.-Doxepin (to treat depression and/or anxiety) HCl 6 mg one tablet by mouth at bedtime related to depressive disorder manifested by sleeplessness, started 3/03/26, and discontinued 3/6/26. Increased with new order 3/6/26, Doxepin HCl 25 mg one tablet by mouth at bedtime related to depressive disorder, new order started 3/06/26.A review of the Medication Administration Record for February 2026 indicated monitoring of episodes anxiousness. There was a total of five episodes of behavior monitored to treat Generalized Anxiety Disorder (GAD) and relieve short-term anxiety symptoms for the month of February. No monitoring for episodes of depression, sleeplessness or sad statements.A review of the Medication Administration Record for March 2026 indicated monitoring of episodes anxiousness and sleeplessness. Records indicate 16 episodes of behaviors monitored to treat GAD and relieve short-term anxiety symptoms for the month of March. Record indicated a total of 126 episodes of sleeplessness for the month of March. No mention of monitoring for episodes of depression or sad statements.A review of Resident 1's Interdisciplinary Team (IDT, group of various medical staff that discuss resident plans of care) notes indicated no mention or documentation of review of Resident 1's behavioral symptoms, response to behavioral medications, or interventions and outcomes in the medical record.A review of Resident 1's order administration note dated 3/1/26 at 10:39 am, indicated Resident 1 continued to have mixed behaviors throughout shift, multiple staff attempted to provide care, Resident 1 frequently became frustrated with staff without clear reasoning, Resident 1 asked multiple staff to exit room but then would call that staff member back in. Resident 1 had delusions and frequently denied previous statements. In-house staff states that this is normal behaviors for this patient. Resident 1 refused offers for interventions frequently.A review of Resident 1's IDT note dated 3/4/26 at 7:48 am, Resident 1 was heard screaming help, help when staff walked in, no call light on. Stated I shit myself, yes I shit myself, are you going to change me. No referrals or changes to orders indicated in record.A review of Resident 1's behavioral note dated 3/17/26 at 7:48 am, Resident 1 was asked to change rooms yesterday and agreed after inappropriate behavior of stripping off his close and making comments that his dyeing roommate smells like PISS and that he was tired of that resident getting all the attention and we only cater to him This was all in front of the roommates family as they were all visiting.A review of Resident 1's social services note dated 3/27/26 at 6:40 pm, found resident mobile in wheel chair leaving social dining screaming at the top of his lungs, stating I'm sick of this shit No one does anything for me here I approached him , Identified myself while he was reading my badge and Resident 1 started hollering, your social services and you haven't done shit for me, get the F*** away from me. I replied, I've placed a call to the Ombudsman's office, and she will be here on Tuesday for your concerns. He told me to go to hell.A review of Resident 1's health status note dated 4/3/26 at 5:33 pm, Resident 1 called the police department and the ombudsman several times today leading to a call from Red Bluff change to local no proper names Police Department and a visit from the ombudsman (resident advocate). Resident 1 was asked what was wrong to which resident gave no real reason as to why he was having behaviors. Resident 1 then was asked again a few minutes later as he was notably verbally upset and he stated that he hated this facility and that he wished he was never sent here to which resident was reminded that he is his own responsible party and may discharge from facility at any time to which resident stated no that he was not leaving and wanted to stay. Resident 1 then stated that he cannot leave facility until he was able to stand or walk and that he was not going to do any of that unless he felt he wanted to and even (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted that he can stand and pivot with little difficulties and was doing so at home but if he began to stand and walk then he would potentially loose his disability benefits and began to say that if he was the type of person if he is unhappy or unsatisfied then he was going to make sure everyone was until they may be up for it. Resident 1 then began to complain about his roommate with no real reason as to why and then begins to complain of finances to which resident was reminded that nursing has nothing to do with insurance or finances to which he called nurse useless and became verbally aggressive yelling profanities at nursing staff. Resident 1 was also noted at time of meals will purposely demand to go into bathroom when trays need to be passed and staff needs to assist un-abled residents with meals and states that he loves to see everyone scramble over his needs needing to be met and stated that that's the way it should be always when it comes to his care.During a review of a health status note dated 4/10/26 at 6:54 am, Resident 1 has refused multiple times to go to the bathroom to be toileted. Resident 1 on every two-hour toileting program, explained to Resident 1 multiple times throughout night shift and this shift. He has a bedside commode (portable toilet) next to bed and the say sit to stand (device used to assist in standing up) was refused. Resident 1 finally agreed to use the sit and stand when assisting him from bed he stated, I can do this myself. Resident was transferred to bathroom via sit to stand.During a review of a health status note dated 4/10/26 at 5:30 pm, Resident 1 was noted to be putting fingers in his mouth and causing self to vomit. When asked why he was doing so he denied happenings even though it was brought to his attention that it was witnessed by several staff members. Resident 1 was educated on the risks from causing self to vomit to which resident stated that he understood the risks but continued denying doing and also continued with behavior.A review of a health status note dated 4/17/26 at 9:56 pm, Resident 1 being monitored due to behaviors, resident has been making sad statements that he wants to die. Resident 1 refused all medications from this LN, stating that taking his medication will make him sick. Resident 1 verbalized not feeling well but does not want help from this LN or MD here. Resident 1 verbalized not wanting to go to hospital either stating I don't trust them. During a concurrent interview and record review 6/9/26 at 10:00 am, Social Services Director (SSD) stated Resident 1 had no behavioral health diagnosis and was not prescribed behavioral health medications. Upon reviewing Resident 1's admission documentation SSD acknowledged that diagnoses of anxiety, personality disorder and depressive episodes as well as medications, were present at admission and stated that these diagnoses and medications had been overlooked during the admission review. SSD confirmed there were no records on mental health referrals and stated, I thought he only had personality disorder and missed the other diagnoses. SSD further stated our staff are not trained in psychiatry or psychological/mental health services.During a concurrent interview and record review on 6/9/26 at 11:20 am, the Director of Nursing (DON) stated Resident 1 declined mental health services and was unable to find documentation in the record of his refusal of mental health service. DON confirmed IDT did not evaluate Resident 1's behavioral symptoms or his response to behavioral medications. DON further explained Resident 1 was very difficult and confirmed they did not consider revising his care plan to include two staff present with all interactions with resident.