

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056274	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Red Bluff Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147</p> <p>Based on observation and interview, the facility failed to provide a clean, safe, comfortable, and homelike environment for seven of 18 sampled residents (Residents 12, 18, 19, 31, 34, 42, and Resident 153) when:</p> <ol style="list-style-type: none"> 1. Four of Four stand up mechanical lifts were unclean. 2. Patio doors to multiple resident rooms were unkept and unclean with cumulative dust and dark and brown debris. 3. Cumulative food and debris was on the floor and under the wooden side table in room [ROOM NUMBER] A. 4. A side table was unkept, faded, with visible chips in the wood in room [ROOM NUMBER] A. 5. Tile was missing on the floor in room [ROOM NUMBER] A. 6. A foot board was unkept, damaged, and had visible chips in the wood in room [ROOM NUMBER] A. 7. Resident privacy curtains had visible red and brown colored stains. 8. The curtains and tracks of the sliding glass doors in the resident rooms were unclean. <p>This failure had the potential to negatively affect client's health, safety, and comfort and the potential to spread other bacteria in the facility to other residents, staff, visitors, and the community.</p> <p>Findings:</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. A review of the facility's policy revised 8/2010, titled, Cleaning and Disinfection of Resident-Care Items and Equipment, indicated resident-care equipment, including reusable items and durable medical equipment (DME) will be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard. DME must be cleaned and disinfected before reused by another resident. Reusable resident care equipment will be decontaminated and/or sterilized between each residents according to manufacturer's instructions.</p> <p>During an observation on 1/7/25 at 10:11 am on the south hall, four of four stand up lifts were unclean with visible dried food particles, cumulative dust, and brown and black colored debris.</p> <p>During an interview on 1/7/25 at 10:12 am, Certified Nursing Assistant (CNA) A confirmed four stand up lifts used to transfer residents were unclean, with cumulative food, dust and debris and these lifts were shared by residents who need this lift for safety for transfers in and out of bed.</p> <p>During an interview on 1/7/25 at 10:45 am, the Director of Nursing (DON) confirmed the mechanical stand up lifts need to be cleaned and sanitized after each use for each resident and two times daily. DON confirmed not cleaning equipment could lead to the spread of infection to other residents and everyone in the facility.</p> <p>2. A review of the facility's policy revised 8/2010, titled, Cleaning and Disinfection of Environmental Surfaces, indicated environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of health care facilities and the OSHA Bloodborne Pathogens Standard. This policy indicated Housekeeping surfaces to include floors, tabletops, will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. Environmental surfaces will be disinfected or cleaned on a regular basis such as daily or three times weekly, and when surfaces are visibly soiled. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled.</p> <p>During an observation on 1/7/25 from 10:15 am to 10:23 am, the patio sliding door windows, tracks, and corners of rooms for residents in Rooms 14, 15, 16, 17, 18, and room [ROOM NUMBER] were unkept and unclean with cumulative dust and dark brown debris. The sliding glass was not clean with visible dust and grime build up.</p> <p>During a follow up interview on 1/8/25 at 12:20 pm, the admin and House Keeping Supervisor (HS) confirmed all of the resident's environment including rooms, floors, sliding glass doors and the tracks of the sliding doors need a deep cleaning. HS stated, The policy does not include deep cleaning, but I will make sure all rooms are deep cleaned on a schedule and as needed moving forward.</p> <p>3. During an observation on 1/7/25 at 10:37 am, there was cumulative food and debris on the floor and under the wooden side table in room [ROOM NUMBER] A.</p> <p>During an interview on 1/7/25 at 11:05 am, the Administrator (admin) confirmed there was a build up of food and debris in room [ROOM NUMBER] A. Admin stated, [Resident 42] needs assistance with feeding, and she drops cookie crumbs in her room.</p> <p>4. During an observation on 1/7/25 at 10:42 am, the wooden side table (nightstand) beside the bed was unkept, faded, with visible chips in the wood in room [ROOM NUMBER] A.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/7/25 at 11:00 am, the admin confirmed the nightstand for Resident 42 needed to be repaired to be cleaned properly and was unkept. The admin stated, I have already ordered many new nightstands for multiple residents, and they should be here in a week or so, it has already been approved.</p> <p>5. During an observation on 1/7/25 at 10:49 am, the floor under the bed in room [ROOM NUMBER] A was missing two tiles underneath the bed of Resident 18.</p> <p>During an interview on 1/7/25 at 11:00 am, the admin confirmed the floor tiles needed to be replaced in room [ROOM NUMBER] A to be cleaned properly for Resident 18.</p> <p>6. During an observation on 1/7/25 at 10:52 am, the foot board of the bed for Resident 12 was unkept, damaged, and had visible chips in the wood in room [ROOM NUMBER] A.</p> <p>During an interview on 1/7/25 at 11:00 am, the admin confirmed the foot board for Resident 12 was unkept, damaged, and needed repair.</p> <p>During a follow up interview on 1/8/25 at 12:20 pm, the admin and House Keeping Supervisor (HS) confirmed all of the resident's environment including rooms, floors, sliding glass doors and the tracks of the sliding doors need a deep cleaning. HS stated, The policy does not include deep cleaning, but I will make sure all rooms are deep cleaned on a schedule and as needed moving forward.</p> <p>7. During a follow up interview on 1/8/25 at 12:30 pm, the admin and HS confirmed resident privacy curtains needed to be replaced if washing the curtains are not removing visible stains. HS stated, We wash the privacy curtains, and it takes about 30 minutes to air dry, but we need more curtains if they are replaced, some of the stains will not come out during washing them.</p> <p>43031</p> <p>8. During an observation on 1/7/25 at 10:48 am, in resident room [ROOM NUMBER], the track to the sliding glass door opening to the patio, appeared to be unclean and have an accumulation of dark brown dirt and debris.</p> <p>During a concurrent observation and interview on 1/7/25 at 11:00 am, with Resident 153 and Family Member (FM) in Resident 153's room [ROOM NUMBER], the sliding glass door track appeared to be unclean with an accumulation of dark brown dirt and debris. Resident 153 and FM stated, we have been here for 3 weeks and the glass door track has been dirty the entire time.</p> <p>During a concurrent observation and interview on 1/7/25 at 11:00 am, with Resident 153 and Family Member (FM) in Resident 153's room [ROOM NUMBER]. The off-white curtain to the sliding glass door was observed with a reddish-brown stain that appeared to have been blotted or cleaned but the stain remained. Resident 153 and FM stated, we have been here for 3 weeks and the stain on the curtain has been here the whole time. It is very noticeable; we have commented to staff, but it is very evident and anyone can see it. I think it is blood on the curtain. It looks like they tried to clean it with something which lightened it and turned it more brownish, but it is very unclean.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 1/7/25 at 12:23 pm, with CNA C in room [ROOM NUMBER], the soiled curtain and sliding glass door track were observed. CNA C stated, I am not sure what is on the curtain, it looks brownish. It is dirty. The door track is definitely dirty, I don't know if anyone cleans it. All of them look like that.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147</p> <p>Based on observation, interview and record review, the facility failed to ensure that Resident 19 was administered an inhaler without following manufacturer's instructions to meet Professional Standards of Care.</p> <p>This failure resulted in and had the potential for the medication to be ineffective for all residents that were ordered an inhaler routinely or as needed (prn).</p> <p>Findings:</p> <p>During a review of a policy revised 10/2021, titled, Administering Medications through a Metered Dose Inhaler, indicated the purpose of this procedure is to provide guidelines for the safe administration of inhaled medications. This policy indicated to explain the procedure to the resident. Administer the medication as follows: Shake the inhaler gently to mix the medication ., remove the cap from the mouthpiece, ask the resident to inhale and exhale deeply for a few breath cycles, on the last cycle, instruct the resident to exhale deeply. Instruct the resident to close his or her lips to form a seal .depress the medication .instruct the resident to inhale deeply and hold for several seconds. Rinse the mouthpiece with warm water.</p> <p>During a review of a record not dated, titled, Albuterol Inhaler Instructions For Use, indicated the following: Shake the inhaler hard 10 to 15 times before each use. Breathe out all the way. Try to push out as much air as you can. Breathe in slowly, Hold the inhaler with the mouthpiece down. Place your lips around the mouthpiece so that you form a tight seal. As you start to slowly breathe in through your mouth, press down on the inhaler one time. Keep breathing in slowly, as deeply as you can. Hold your breath, Take the inhaler out of your mouth. If you can, hold your breath as you slowly count to 10. This lets the medicine reach deep into your lungs. Pucker your lips and breathe out slowly through your mouth. If you are using inhaled, (beta-agonists), wait 1 to 2 minutes before you take your next puff. You do not need to wait between puffs for other medicines. Put the cap back on the mouthpiece and make sure it is firmly closed. After using your inhaler, rinse your mouth with water, gargle, and spit. Do not swallow the water. This helps reduce side effects from your medicine.</p> <p>A review of Resident 19's clinical record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD, a progressive lung disease), muscle weakness, hypercalcemia (high calcium levels in the blood), heart disease and depressive episodes (constant feelings of sadness, loss of interest in doing activities). This record also indicated Resident 19 is his own responsible party (able to make medical decisions).</p> <p>During a review of Resident 19's medical record a document dated 1/9/25, titled, Active Orders, indicated Albuterol Sulfate 90 micrograms (Mcg, a unit of measurement) one puff every 4 hours inhalation as needed for wheezing.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 1/9/25 at 7:20 am, Licensed Nurse (LN) 2 handed the inhaler medication albuterol 90 mcg to Resident 19 as ordered, and did not provide any instructions for Resident 19 for breathing techniques for effectiveness and per manufacturer's guidelines as follows: Before you breathe in your dose from the inhaler, breathe out (exhale) as long as you can, inhale one puff of the albuterol inhaler, remove the inhaler from your mouth and hold your breath for about 10 seconds, or for as long as comfortable for you. Breathe out slowly as long as you can.</p> <p>During an interview on 1/9/25 at 9:05 am, the Director of Nursing (DON) confirmed the medication for Resident 19's inhaler was not administered correctly by LN 2 by not giving specific breathing instructions. DON stated, Resident 19 has COPD, and he might need a spacer, but I will do an inservice to all nurses to correctly administer all inhalers for effectiveness.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147</p> <p>Based on observation, interview, and record review, the facility failed to ensure oxygen equipment was monitored, changed, and dated as ordered for two out of five sampled residents (Resident 1 and Resident 34) when:</p> <ol style="list-style-type: none"> 1. The oxygen tubing for Resident 1 was dated 12/25/24 during an observation on 1/7/25. 2. The oxygen bottle for Resident 34 was empty, not full of bubbling water and dated 12/1/24, and the oxygen tubing for Resident 34 was dated 12/25/24. <p>This failure had the potential to cause discomfort, and the spread of infection to the residents, staff, and visitors.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of the facility's policy revised 10/2010, titled, Oxygen Storage and Use, indicated the purpose of this policy is to provide safe storage and use of oxygen equipment. <p>A review of Resident 1's medical record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included surgical aftercare of the digestive system, a colostomy (an opening for bowel elimination), diabetes, Chronic Pulmonary Obstructive Disease (COPD, a progressive lung disease), and heart disease.</p> <p>A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) for Resident 1 dated 10/4/24, indicated that Resident 1 had a moderate cognitive deficit, with a brief interview for mental status (BIMS) score of 8 out of 15, and needed moderate assistance from staff with all activities of daily living (ADLs, basic needs as personal hygiene, dressing, toileting, transferring, walking, and eating).</p> <p>A review of Resident 1's medical record indicated a document dated 1/2025, titled, Active Orders, indicated Resident 1 was ordered Oxygen 2 liters (l) via nasal canula (n/c) to maintain oxygen levels above 90%.</p> <p>A review of Resident 1's medical record indicated a document dated 1/2025, titled, Active Orders, indicated Resident 34 was ordered change oxygen tubing every seven days and date and label all components every week on Tuesday.</p> <p>During an observation on 1/7/25 at 11:14 am, the oxygen tubing being used by Resident 1 was dated 12/25/24, seven days late being changed per the facility policy and orders.</p> <p>During an interview on 1/7/25 at 3:15 pm, the Director of Nursing (DON) confirmed the oxygen tubing needed to be changed for Resident 1, dated 12/25/24 every seven days and as needed.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. A review of the facility's policy revised 10/2010, titled, Oxygen Administration, indicated the purpose of this procedure is to provide guidelines for safe oxygen administration. The following equipment and supplies will be necessary when performing the procedure humidifier bottle. Check the mask, tank, humidifying jar to be sure they are in good working order and securely fastened. Be sure there is water in the humidifying jar and the water level is high enough that the water bubbles as oxygen flows through Periodically re-check water level in the humidifying jar. Report other information in accordance with facility policy and professional standards of practice.</p> <p>A review of Resident 34's medical record indicated Resident 34 was admitted to the facility on [DATE] with diagnoses that included palliative care (specialized medical care for serious illness), acute respiratory failure (a condition when the lungs cannot get enough oxygen in the blood), heart disease, dependence on oxygen therapy, and dysphagia (difficulty swallowing).</p> <p>A review of the most recent MDS, for Resident 34 dated 9/15/24, indicated that Resident 34 had a moderate cognitive deficit, with a BIMS score of 10 out of 15, and needed maximum assistance from staff with all activities of daily living (ADLs, basic needs as personal hygiene, dressing, toileting, transferring, walking, and eating).</p> <p>A review of Resident 34's medical record indicated a document dated 1/2025, titled, Active Orders, indicated Resident 34 was ordered Oxygen 2 l via n/c to maintain oxygen levels above 90%.</p> <p>A review of Resident 34's medical record indicated a document dated 1/2025, titled, Active Orders, indicated Resident 34 was ordered change oxygen tubing every seven days and date and label all components every week on Tuesday.</p> <p>During an observation on 1/7/25 at 11:55 am, the oxygen water humidifier bottle was empty, there was no water present, and the date on the water bottle was 12/1/24. The oxygen tubing being used by Resident 34 was dated 12/25/24.</p> <p>During an interview on 1/7/25 at 2:54 pm, Licensed Nurse (LN) 4 stated, Our oxygen policy is change every Sunday on noch shift, but we should double check to make sure it is done for all residents using oxygen. The oxygen tubing and bags on the bedside and on wheelchairs and the water bottles should be changed every week. LN 4 confirmed not changing oxygen equipment per policy could cause an infection for residents that require oxygen administration.</p> <p>During an interview on 1/7/25 at 3:17 pm, the DON confirmed the oxygen water bottle humidifier for 34 should have never run low on water and needed to be changed. The DON also confirmed the oxygen tubing Resident 34 was using needed to be changed and any equipment not changed as ordered and per policy could cause a respiratory infection including pneumonia. DON stated, I will re-educate all the nurses because it is on the Treatment Administration Records to document, and the oxygen equipment should be changed per the orders.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147</p> <p>Based on interview and record review, the facility failed to document behaviors for an antipsychotic (medication used for moods and behaviors to treat mental illness) medication used for one of three sampled residents (Resident 31).</p> <p>This failure had the potential to not identify an increase in behaviors, identify new interventions needed, and a change in condition that should be reported to the physician for medication management.</p> <p>Findings:</p> <p>A review of the facility's policy revised 12/2016, titled, Antipsychotic Medication Use, indicated residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications.</p> <p>A review of the facility's policy revised 12/2016, titled, Behavioral Assessment, Interventions, and Monitoring, indicated behavioral symptoms will be identified using the facility approved behavioral screening tools and the comprehensive assessment. The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes. This facility policy also indicated 10, .when medications are prescribed for behavioral symptoms, documentation will include and specific target behaviors and expected outcomes, and monitoring for efficacy and adverse consequences.</p> <p>A review of Resident 31's medical record indicated Resident 31 was admitted to the facility on [DATE] with diagnoses that included diabetes (too much sugar in the blood), high blood pressure, epilepsy (seizures), Parkinson's disease (a progressive brain disorder that causes involuntary movements such as shakiness and tremors) and Bi-Polar disorder (a mental health condition that causes extreme mood swings).</p> <p>A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) for Resident 31 dated 11/20/24, indicated that Resident 31 had a very mild cognitive deficit, with a brief interview for mental status (BIMS) score of 13 out of 15, and needed moderate assistance from staff with all activities of daily living (ADLs, basic needs as personal hygiene, dressing, toileting, transferring, walking, and eating).</p> <p>A review of Resident 31's medical record indicated a document dated 1/2025, titled, Active Orders, indicated Resident 31 was ordered Seroquel (an antipsychotic medication used for moods and behaviors) 25 milligrams (mg, a unit of measure) give one tablet by mouth at bedtime.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 31's medical record indicated documents dated 10/1/24 through 1/7/25, titled, Medication Administration Record (MAR), indicated only one behavior was documented on 11/16/24 for monitoring of manic (sudden and severe changes in mood, such as going from being joyful to being angry and hostile. Restlessness. Rapid speech and racing thoughts) episodes.</p> <p>During an interview on 1/9/25 at 9:20 am, the Director of Nursing (DON) confirmed the behaviors by Resident 31 were not documented appropriately on the MARs and she would complete an inservice for all the nursing staff to track specific behaviors and report as indicated. DON stated, They have an area to document behaviors on the MAR, but they are not tracking them. The progress notes for Resident 31 indicate behaviors and the medication is needed for moods.</p>		