STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05A371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Wellness and Recovery Center	3062 Churn Creek Rd. Redding, CA 96002

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to protect the rights of one out of four sampled residents (Resident 1) to be free from physical abuse by Resident 2 when Resident 2 hit Resident 1 in the face. This resulted in Resident 1 sustaining bruising to the right side of the face that lasted for 15 days. Findings: A review of the facility's policy and procedure (P&P) titled, Crisis Intervention Program, updated 6/1/25, indicated, facility staff would recognize early warning signs of crisis (notice changes in behavior, mood, or thinking). The P&P indicated staff would provide early intervention (action and support provided to the resident from staff) when a resident exhibited an increase in behaviors (acting out). A review of the Certified Nurse Assistant [CNA] Job Description, updated 10/30/25, indicated, the CNA would report all changes, including agitation (feeling anxious, worked up, or irritable) to the Shift Coordinator (SC) immediately. A review of Resident 1's admission Record, dated 8/24/18, indicated that Resident 1 was admitted to the facility on [DATE] with the diagnosis of schizoaffective disorder (schizophrenia, serious brain disorder that disrupts how a person thought, felt, or behaved, causing them to lose touch with reality and a mood disorder at the same time), bipolar (a mood disorder that caused extreme mood swings) type. Resident 1 was conserved (the courts appointed a conservator who made all decisions for the resident). A review of Resident 1's Annual Minimum Data Set (MDS, a resident assessment tool) titled, Section E-Behaviors, dated 10/6/25, indicated Resident 1 had delusions (believing in something that was not true) and verbal behavioral symptoms (threatening, screaming, and cursing) that were directed towards others. The MDS indicated Resident 1 intruded (barged in, placed self where one was not wanted) on others privacy and activities. The MDS indicated, Resident 1 significantly disrupted care or the living environment of others. A review of Resident 2's admission Record, dated 2/2/18, indicated that Resident 2 was admitted to the facility on [DATE] with the diagnosis of schizophrenia. Resident 2 was conserved. A review of Resident 2's Quarterly MDS, titled Section E-Behaviors, dated 9/1/25, indicated that Resident 2 had delusions. A review of Resident 2's Quarterly MDS, titled Section C-Cognitive Patterns (brain function), dated 9/2/25 indicated Resident 2 experienced signs and symptoms of delirium (a sudden and severe state of mental confusion, change in usual behavior, and ability to think). A review of Resident 2's Progress Note, dated 11/2/25, indicated, on 11/2/25 at approximately 9:25 am, Resident 2 felt threatened when Resident 1 put her fists up as if they were going to fight and Resident 2 hit Resident 1 in the face approximately three times. During an interview on 1/6/26 at 2:26 pm, Certified Nurse Assistant (CNA) A stated, Resident 2 hit Resident 1 because Resident 1 was making threats to Resident 2 every single day. CNA A could not verbalize how many days Resident 1 had been verbally threatening Resident 2 and clarified threats as death threats. CNA A indicated, when a resident made verbal death threats to another resident, the SC was notified, the residents were separated with a room change, and then placed on welfare checks every 15 minutes. CNA A stated, Resident 2 (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted she only did that to Resident 1, because Resident 2 felt like she was being verbally attacked by Resident 1. CNA A confirmed reporting Resident 1's death threats to the SC and could not verbalize who it was reported to. During an interview on 1/7/26 at 1:01 pm, Licensed Nurse (LN) C stated, Resident 1 was experiencing an increase in psychosis (a loss of touch with reality), high anxiety, and screaming episodes. She [Resident 1] has paranoia (an intense feeling that people are out to get you) and delusions increase when psychosis increases. This all happened slowly over a few days. LN C confirmed having no knowledge that Resident 1 had been making death threats. During an interview on 1/7/26 at 1:49 pm, CNA A stated, I heard Resident 1 yelling I'm going to kill you, on the day it happened (11/2/25). CNA A confirmed, Resident 1 and Resident 2 were roommates on the day of the physical abuse and stated, they were both in their room. I'm not positive it was said directly to Resident 2, or if Resident 1 was just yelling it. CNA A confirmed that CNA A did not enter the room to ensure resident safety or to investigate what was happening. CNA A confirmed an inability to verbalize what the time frame was between Resident 1 making a death threat to the time Resident 2 had punched Resident 1 in the face. During a concurrent interview and record review on 1/7/26 at 2:02 pm, CNA B indicated that Resident 1 had delusions that she was married to Elvis. CNA B stated, I've heard Resident 1 have outbursts, not specific to I'm going to kill you, but yelling regarding a delusion, my husband is Elvis, there is a woman after him, and I'm going to kill her. CNA B reviewed Resident 1's Progress Notes, dated 5/5/25 through 12/25/25 and confirmed, there was no CNA documentation present that indicated that any CNA had witnessed Resident 1 making verbal death threats during reoccurring delusions. During an interview on 1/7/26 at 2:17 pm, LN D confirmed working the morning of 11/2/25 and stated, I've never heard anything about Resident 1 yelling death threats. LN D confirmed, Resident 1 had delusions that Resident 1 was married to Elvis and stated, Resident 1 yells that she wants to kill the woman after her husband. LN D confirmed, when Resident 1 yelled I'm going to kill you, that indicated a change in behavior, it should have been reported to LN D, and was not. LN D stated, if the CNA told me about her observation, I would have gone in and assessed the situation and seen what was going on, determine if [Resident 1's] statement of killing you was regarding a delusion or her roommate. I could have redirected or separated them. Had someone came and told me about it, I would have been in there to attempt to deescalate the incident before it happened. A review of the Skin Observation assessment, dated 11/2/25, indicated, LN C assessed Resident 1 after the physical abuse. The assessment indicated, Client has reddened areas on her neck and right side of face. Brusing is starting to develop on her right side and left side chin. A review of the Skin Observation assessment, dated 11/17/25, indicated the bruising to the right side of Resident 1's face had resolved (15 days after Resident 2 hit Resident 1). During an interview on 1/7/26 at 2:53 pm, Director of Nursing (DON) stated, CNA's start their shift at 6:30 am. DON confirmed, the incident between Resident 1 and Resident 2 occurred at approximately 9:50 am (there was three hours and 20 minutes from the time CNA A clocked in, and Resident 2 physically abused Resident 1). During an interview on 1/7/26 at 3:01 pm, Wellness and Recovery Director (WRD), DON, and Assistant Director of Nursing (ADON) confirmed, no staff had notified them that on the morning of 11/2/25, Resident 1 had yelled I'm going to kill her. WRD, ADON, and DON confirmed, CNA A's observation of Resident 1 yelling, I'm going to kill you, should have been reported to the SC. During in interview on 1/8/26 at 11:17 am, SC F stated, if a CNA is walking down the hall and heard a resident state I'm going to kill you, they should put eyes on them and see what's going on. It should have been reported to the nurse, bare minimum the medication nurse [LN] should have been notified. If I had been notified, I would have investigated and separated them.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to report an allegation of sexual abuse to the California Department of Public Health (CDPH, state agency dedicated to protecting and improving the health of Californians), the police department, and to the local Ombudsman [a person who worked to maintain resident rights] for one out of two sampled residents (Resident 3) when Resident 3 made statements about being sexually abused. This had the potential to negatively impact health status and psychosocial well-being. Findings: A review of the facility's policy and procedure (P&P) titled, Client Abuse Prevention, updated 10/14/24, indicated, Staff will immediately and directly report to the Administrator any suspicions of client abuse, either witnessed or suspected. The P&P indicated, Due to the complexity of the clients being served by this facility (i.e., the seriously mentally ill), all reports of abuse will be initially screened by the Administrator or designee for the possibility of reality-based accusation (i.e., a flying dragon injured me, etc.,). All reality-based accusations will be immediately investigated and reported to officials in accordance with state law (including the state licensing and certification agency [CDPH]). A review of Resident 3's admission Record, dated 7/29/16, indicated, Resident 3 was admitted to the facility on [DATE] with the diagnosis of schizoaffective disorder (schizophrenia, serious brain disorder that disrupts how a person thought, felt, or behaved, causing them to lose touch with reality and a mood disorder at the same time), bipolar type (a mood disorder that caused extreme mood swings). Resident 3 was conserved (the courts appointed a conservator who made all decisions for the resident). A review of Resident 3's Annual Minimum Data Set (MDS, a resident assessment tool), dated 12/30/25, indicated, a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgment status of the resident) was conducted. Resident 3 scored a 15-out-of 15, which indicated intact memory, orientation, and judgement. A review of Resident 3's Annual MDS, dated [DATE], section E-Behaviors, indicated that Resident 3 experienced hallucinations (seeing or hearing things that were not there) and delusions (believing in something that was not true). During a concurrent interview and record review on 1/8/26 at 11:33 am, with Wellness and recovery Director (WRD), a review of the SOC 341(a specific form used in California to report known or suspected abuse), dated 1/6/26 was reviewed. WRD confirmed the SOC 341 included an email that WRD had sent to Resident 3's Public Guardian's (also known as the conservator) office on 1/2/26 that indicated that a peer was having sex with Resident 3 without her consent and the facility had investigated the allegation. WRD stated, if I remember right, we were in a team meeting and I believe the nurse said it. After the allegation was made, during the team meeting, regarding the peer on 1/2/26, me and the Administrator (ADMIN) investigated after the meeting. WRD provided a Social Services Note, dated 1/2/26. WRD confirmed, the Social Services Note, indicated, WRD received an email from a Licensed Nurse (LN) that indicated, Resident 3 made an allegation of assault, and stated to the LN, .she felt that a peer was coming into her room and having sex with her without her consent. The Social Services Note indicated, It is noted that her statement was demonstrably similar in nature to previous unverifiable accusations of others. During a concurrent observation and interview on 1/8/26, at 1:25 pm, Resident 3 was observed calmly walking up to the nurse's station and had a normal rate and tone of speech during introductions. Resident 3's hands began to shake, and her speech became rapid and loud. Resident 3 stated, No! I never said that, why would they keep saying that? During Resident 3's statement, her head was moving from side to side, there was a tremble in her voice, and she was looking at the floor. Resident 3 was asked who they were, and Resident 3 indicated LN C. Resident 3 was no longer standing (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	still and was moving from side-to-side and immediately ended the interview. During a concurrent interview and record review on 1/8/26 at 1:59 pm, ADMIN provided an email, dated 1/1/26. ADMIN confirmed, LN C sent an email to WRD and the Director of Nurses. ADMIN confirmed, the email indicated, She then began stating that people come into her room and rape her when she isn't fully awake. The words rape and fully awake contained quotation marks, indicating Resident 3 said those words while talking to LN C. During an interview on 1/8/26 at 2:08 pm, LN C stated, Resident 3 never told me that someone raped her. I sent a communication follow up to WRD. LN C indicated, LN C did not send WRD an email, and stated, it was an internal communication, my concern is she has a fixation of becoming pregnant and was expressing a plan of becoming pregnant. During an interview on 1/9/26 at 10:23 am, ADMIN described what should happen when there is an allegation of sexual abuse. ADMIN stated, We should take steps to keep residents safe, notify the police, DHS [social services, assisted with providing essential services], [CDPH, and the Ombudsman within two hours. ADMIN confirmed Resident 3's allegation of sexual abuse was not reported.