

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Surprise Valley Community Hospital D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 741 N. Main Street Cedarville, CA 96104	

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 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. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to report to the California Department of Public Health (CDPH), a physical abuse allegation immediately or within two (2) hours for one of three sampled residents (Resident 1), when Resident 1 made an allegation that she was treated rough during a shower and this was not reported to the facility's Abuse Coordinator or to CDHP in accordance with the facility's Abuse Policy. This failure had the potential of creating an environment where abuse allegations are not timely reported to the appropriate agencies, and result in all residents being at risk of physical and emotional abuse without appropriate investigations, leading to an unsafe environment for residents and no consequences for an actual abuser. During a review of the facility's Policy and Procedure titled, Abuse Reporting and Investigation, dated 5/12/22, indicated, All reports of resident abuse are reported to local, state (CDPH), and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury. Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. During a review of Resident 1's medical record, Resident 1 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills, leading to severe impairment in daily functioning), Dementia (progressive organic brain disorder with persistent loss of intellectual functioning, memory impairment, and personality change) with agitation and Mood Disturbances, and Depression. Resident 1's most recent Minimum Data Set (MDS, tool for evaluating and implementing a standardized general assessment of residents), dated 11/19/25, was reviewed. Section C, Brief Interview for Mental Status (BIMS, assessment of cognitive function), reflected Resident 1 scored 99, which equates to cognition being severely compromised. Resident 1 was not their own Representative (RP) and does not make their own medical decisions but is able to express needs and desires verbally. During a review of the document titled, Report of Suspected Dependent/Elder Abuse, State of California (SOC-341), was completed by the facility on 12/9/25 and not submitted to CDPH until 12/10/25 at 1:43 pm. The form indicated the Director of Nursing (DON) was informed by Activities Director (AD) that Resident 1 complained that Certified Nursing Assistant (CNA) B, has been rough with Resident 1 during a shower. AD documented she had heard people talking about this allegation for a couple of weeks. During an interview on 12/18/25 at 1:15 pm, with AD on the telephone, AD stated that during Resident Council (monthly meeting of residents to discuss issues and concerns regarding the facility) Resident 1 stated she was treated roughly in the shower, but she did not recall when. AD concurred there were rumors among staff about the allegation for a few weeks. AD confirmed she had not reported the allegation to the Abuse Coordinator or to the DON, until 12/9/25. During an interview on 12/18/25 at 2:15 pm, with Licensed Vocational Nurse (LN) A in the conference room, LN A stated, I made a mistake. I did not report the allegation when it initially was reported to me [by CNA C]. I should have reported the allegation when it occurred. I do not recall when it occurred but it was awhile back. During an interview on 12/18/25 at 2:45 pm, with CNA C in the conference room, CNA C stated they informed LN A of the abuse allegation from Resident 1 regarding an incident in the shower, but they did not follow up and make sure the LN A formally reported the allegation. CNA C could not recall when the allegation was made but thought perhaps it was at the end of October 2025. During an interview on 12/19/25 at 7:40 am, with DON in the conference room, DON confirmed staff did not report the abuse allegation in accordance with the facility's Abuse Policy. The DON confirmed the notification of alleged abuse was made late to CDPH.</p>		