STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555281	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oroville Hospital Post-Acute Center	1000 Executive Parkway Oroville, CA 95966

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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 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 and interview the facility failed to maintain food safety requirements in the kitchen for all residents receiving their nutritional intake from the kitchen when a gallon of milk and a jar of dill pickle relish were not labeled with the open date following the opening and use of the products.This failure had the potential to result in improper prolonged, out of date use leading to disease transmission, increasing environmental health complications, and overall wellbeing issues to those residents' receiving their nutritional intake from the facility kitchen.Findings:During a review of facility's policy and procedure titled, Labeling and Dating of Foods, dated 2023, indicated, Newly opened food items will need to be closed and labeled with an open date and use by the date that follows the various storage guidelines.During an observation and interview on 5/5/26 at 11:00 am, with Dietary Service Manager (DSM) in the kitchen the three-door refrigerator was observed for adequate food storage. The DSM confirmed that the gallon of milk and jar of pickle relish were not labeled with opening dates as per the regulation guidelines.

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview, and record review, the facility failed to submit the required Payroll Based Journaling (PBJ), staffing information to the Centers for Medicare and Medicaid Services (CMS).This failure has the potential for nursing homes to have inadequate staffing to care for residents and can lead to adverse clinical outcomes. Findings:During a concurrent interview and record review on 5/5/26 at 8:00 am., with the Director of Nursing (DON), the PBJ reporting data was reviewed, the PBJ indicated the CASPER report 1705D fiscal year quarter 1 2026 (October1 - December 31), the facility failed to submit data for the quarter. DON stated they tried to submit the PBJ, but their password didn't work and they did not contact CMS in a timely manner.The facility was unable to provide evidence, by the conclusion of the survey on 5/8/26, demonstrating compliance with the regulatory requirement to submit Payroll-Based Journal (PBJ) data and reports to CMS.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain essential equipment in operable condition affecting all residents that partake in nutrition provided by the kitchen facility and residents using bathroom units when:1. The oven in the kitchen had broken doors rendering the unit inoperable to perform the function of cooking.2.The wall by the dishwasher unit had incomplete repairs performed leaving the drywall open to moisture, and potential mold and bacterial growth which could result in infection control issues and food borne illness propagation.3.The bathroom facilities, sink and toilet, in room [ROOM NUMBER] were not working. These failures had the potential to create an inhospitable environment for residents to reach their highest practicable level of health and well-being when not offered the basic essentials for adequate nutrition and available facilities at their procurable disposal.Findings: During a review of the document titled, Job Description for the Maintenance Director, dated 4/1/2022, the Maintenance Director Job Description indicated that the maintenance director was to ensure the operations of the maintenance department in making repairs and conducting preventative maintenance. Essential Functions (included) Perform carpentry work.Assist carpenters on maintenance (including) Repair plaster and drywall.Maintain plumbing systems and fixtures.Maintain and repair kitchen equipment (fryers, steamers, stoves, ovens.) .Repair and replace faucets, drains. During a review of the document titled, Job Description for the Maintenance Technician, dated 4/1/2022, the Maintenance Technician Job Description indicated, the technician was to perform repairs and maintenance on facility structures. Essential Functions (included) Perform carpentry work.Assist carpenters on maintenance (including) Repair plaster and drywall.Maintain plumbing systems and fixtures.Maintain and repair kitchen equipment (fryers, steamers, stoves, ovens.).Repair and replace faucets, drains. 1.During an observation and interview on 5/5/26 at 09:45 am, with AM [NAME] (AMC) in the kitchen, the oven was observed to have broken doors. AMC stated that the oven had been broken for quite some time, they (kitchen staff) could not use it to cook food, but just to warm plates. During an observation and interview on 5/5/26 at 11:00 am, with Dietary Service Manager (DSM) in the kitchen, the oven was observed to have broken doors. DSM stated that the oven doors have been broken for greater than seven months, it doesn't appear to be fixable because of the age of the unit. Maintenance has tried to fix the oven, but it keeps breaking. The oven cannot be used to cook anything; roasts have to be purchased precooked and just warmed up in the small standing convection oven or small standing steamer. The broken oven makes it very difficult to prepare the best meals for the residents, especially in a timely manner. During a confidential interview on 5/5/26 at 2:00 pm, five of five residents indicated the food quality could be improved upon and oftentimes food service seemed to be late. During an interview on 5/6/26 at 10:30 am, with the Registered Dietician (RD) in the kitchen, the RD stated that the oven has been broken for a while. The oven is necessary to make the best food for the residents and to do an efficient and effective job in the kitchen. During a concurrent interview and record review on 5/7/26 at 3:30 pm, with Maintenance Service Director (MS) and Maintenance Service Assistance (MSA) outside the Maintenance office, MS and (continued on next page)

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	555281	A. Building B. Wing	05/08/2026

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	MSA confirmed there was no policy on the maintenance of equipment for the entirety of the facility. The document titled, Preventative Maintenance Task Sheet dated January 2026 through May 2026, was reviewed for the Wolf Range Vulcan (stove/oven brand). The sheet indicated what services were performed each month and what was unable to be completed for specific reasons. The sheet indicated that the oven doors were not properly working from January 2026 to May 2026 and the explanation was provided under Comments: 1/15/26 Need's repairs done on oven door's will be done ASAP (As soon as possible). MS confirmed the oven needed to be fixed. 2.During an observation and interview on 5/5/26 at 11:00 am, with Dietary Service Manager (DSM) in the kitchen, the wall by the dishwasher was observed to be under construction with open areas revealing unfinished drywall (porous flat panel used in construction for wall structuring). DSM stated, The wall by the dishwasher was being renovated but the work has never been completed. The dishwashing area is very wet and is damaging the open drywall, it needs to be completed. During a concurrent interview and record review on 5/7/26 at 3:30 pm, with Maintenance Service Director (MS) and Maintenance Service Assistance (MSA) outside the Maintenance office, MS and MSA confirmed there was no policy on the maintenance of equipment for the entirety of the facility. MS confirmed the wall by the dishwasher needed to be fixed. During an interview on 5/7/26 at 4:40 pm, with Director of Nursing (DON) in DON's office, DON stated there is no policy on equipment maintenance and equipment being operable for and within the facility. DON confirmed that the oven needs to work, and wall must be completed. 3.During an observation on 05/07/2026 at 2:35 PM, room [ROOM NUMBER]'s bathroom was observed to have a sign that indicated out of order. The caregiver of a resident stated he was informed that there was a root growing out of the toilet. A review of an invoice from a local plumbing company dated 4/6/2026, indicated they ran a cable 10 feet into the toilet and there was mud on the end of the cable. During a concurrent interview and record review on 5/07/26 at 2:30 pm, MSA confirmed the sink and toilet do not have running water in room [ROOM NUMBER]. MSA provided the facility repair log, and it indicated the problem was reported on 4/7/26. A local plumbing company came out and put a camera down the water pipe. MSA stated the pipe had disintegrated and can no longer be used. During a interview on 05/08/26 7:50 am, MS confirmed room [ROOM NUMBER] toilet and sink were not working. MS stated there was no capital expense plan to repair the bathroom water pipe in room [ROOM NUMBER].

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and home-like environment for four of 24 sampled residents (Residents 34, 42, 45, and 59) when the facility failed to maintain resident's personal clothing and belongings, resulting in lost clothing items.This failure had the potential to compromise residents' dignity, comfort, and quality of life.Findings:During a review of the facilities policy titled, Theft and Loss Control, undated, indicated the facility would make efforts to safeguard residents' personal property and valuables and that suspected loss or theft of resident property would be timely and thoroughly investigated. The policy further indicated residents clothing was to be permanently labeled with a laundry marking pen or identifying tag. During a review of the facility policy titled, Notice of Theft and Loss Control Policy, undated, indicated staff would be oriented to theft and loss investigation procedures upon hire and during regular in-service training, that staff were to complete a grievance form when notified of a missing item, and that social services would initiate an investigation upon receipt of the grievance form. During a review of the facilities policy titled, Personal Care Items and Clothing, undated, the policy indicated that residents are to have personal care items and clothing available, and that social services are to distribute or arrange for donated items for residents with little or no resources.During a review of Resident 34's admission Record, the record indicated that Resident 34 was admitted on [DATE] with diagnoses that included, Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing) ,Seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), Cerebrovascular Accident (CVA-stroke, loss of blood flow to a part of the brain), and high blood pressure. During a concurrent observation and interview on 5/5/26 at 8:17 am, with Resident 34, in Resident 34's room, Resident 34 stated, that 20 labeled pairs of socks sent to the laundry were never returned. Resident 34 also stated that a pink dress sent to laundry in a bag labeled with their name for identification was not returned. Residents 34 stated they had not received the missing items and that no one had followed up with them regarding the loss. Observation of the residence closet revealed no socks or pink dress present. During a review of Resident 42's admission Record, the record indicated that Resident 42 was admitted on [DATE] with diagnoses of end stage renal disease (the kidneys [an organ that filtered waste from the blood] no longer functioned well enough to support life) and dependence on renal dialysis. During a review of a resident council facility grievance form, dated 11/26/25, indicated, that clothing was removed from Resident 42's clothing hamper by an unknown individual. During a review of a Social Service note, dated 1/5/26, indicated, Resident 42 continued to have missing personal items, including two phone charging cords, a pedal bike charging cord, and a silver necklace with a black stone. During a review of a resident council facility grievance form, dated 1/2/26, indicated, that a resident reported that clothing was not being consistently returned from laundry. The grievance form indicated the clothing was not returned to the resident until 2/1/26, 11 days after the grievance was initiated. During a review of Resident 45's admission Record, the record indicated that Resident 45 was admitted on [DATE] with diagnoses that included, Lung Cancer, COPD, Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and high blood pressure. During an interview on 5/6/26 at 2:00 pm, with Family Member (FM) 1, in Resident 45's room, FM 1 stated, they had purchased several pajama sets for Resident 45 and multiple pajama tops were missing. FM 1 stated Resident 45 also had a blanket go missing and had received items that did not belong to them. FM 1 further stated Resident 45 lost her phone during a fire evacuation standby and it was never replaced. FM 1 stated they were told there was no facility lost and found by staff. During a review of Resident 59's admission Record, the record indicated that Resident 59 was admitted on [DATE] with diagnoses that included, Kidney Disease, (continued on next page)

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	555281	A. Building B. Wing	05/08/2026

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	COPD, DM, Heart Failure (HF, heart pumps blood inadequately), and high blood pressure. During a concurrent observation and interview on 5/7/26 at 4 pm, with Resident 59, in the resident's room, Resident 59 stated that a dark navy pair of pants sent to the laundry had not been returned despite notifying laundry and nursing staff. Resident 59 stated that approximately 2 weeks ago a staff member brought her a red pair of pants removed from her roommate and told her that the clothing needed to be better labeled. Resident 59 stated that clothing items belonging to her roommate had been found in her closet and that her own clothing had been found in her roommate's closet. Resident 59 stated she does not have many clothes that fit her and that losing clothes is frustrating. An observation of the residence closet revealed no dark navy pants were present. During an interview on 5/7/26 at 4:18 pm, with Licensed Nurse (LN) A, LN A stated, that Resident 59's clothing had previously been found in the roommate's closet. LN A stated that the clothing was unlabeled and was sent to laundry to be labeled. During an interview on 5/7/26 at 4:50 pm, with the facility Environmentalist (ENVIR), ENVIR stated, the facility maintained one lost and found clothing rack and that unclaimed items were moved to a donation rack after 30 days. Clothing may be lost during room changes, when items are not properly labeled upon admission or by families, or when personal laundry is mistakenly sent to that facility laundry, and unlabeled clothing made items difficult to return to residents, particularly for residents who are unable to identify their belongings. ENVIR confirmed the facility had a large amount of lost and found clothing and could benefit from a better system for returning clothing to residents. During an interview on 5/7/26 at 11:14 am, with Social Services (SS), SS stated, that residents had reported missing belongings, including clothing. SS department worked with laundry staff to locate and return missing items, but unlabeled belongings made ownership difficult to determine once items reached the laundry, and there was hesitation in returning items from the lost and found area without confirming ownership. SS confirmed the facility had a large amount of lost and found clothing and that the process of returning belongings could be improved.During a concurrent observation and interview on 5/7/26 at 3 pm with the Director of Nursing (DON) in the laundry room, a large quantity of lost clothing items was observed. The DON confirmed that a new process was needed to address the lost and found clothing issues and improve management of resident clothing.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete:The admission Minimum Data Set (MDS) assessment in a timely manner for one of five sampled residents (Resident 123).The Annual MDS assessments for two of five sampled residents (Residents 14 and 126).These failures had the potential to delay the development of comprehensive care plans necessary to provide appropriate, individualized care and services for Residents 14, 123, and 126 to attain and maintain their highest practicable physical, mental, and psychosocial well-being.Findings:A review of the he Centers for Medicare & Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual, dated 10/1/25. The RAI Manual requires admission MDS assessments to be completed within 14 calendar days of admission and Annual MDS assessments within 14 days of the Assessment Reference Date (ARD-the specific endpoint of a look-back period for an MDS assessment in long-term care).A review of Resident 123's clinical records indicated Resident 123 was admitted on [DATE], with the admission MDS due by 5/1/26. As of 5/2/26, the admission MDS remained in progress with no care areas documented, exceeding the required completion timeframe.A review of Resident 126's clinical record indicated Resident 126 was admitted on [DATE] with diagnoses that included dementia, seizures, and irregular heart rate. A review of Resident 126's most recent MDS assessment, with an ARD of 4/21/26, due by 5/5/26. The assessment was three days overdue. A review of Resident 14's clinical record indicated Resident 14 was admitted on [DATE] with diagnoses that included history of falling, diabetes (high blood sugar), and chronic pain. A review of Resident 14's most recent MDS assessment, with an ARD of 4/17/26, due by 5/1/26. The assessment was seven days overdue. During a concurrent interview and record review on 5/7/26 at 10:35 am, with MDS Nurse (MDSN) A, the MDSN A stated admission MDS assessments are Supposed to be done in seven days however it is not always done in this time frame. MDSN A stated, this facility is A beast and it is difficult to complete these assessments on time due to the patient population, acuity (severity and urgency of the resident's medical conditions), and frequent turnover (resident admissions and discharges). During a concurrent interview and record review on 5/7/26 at 12:01 pm, with MDSN A, the MDSN A stated the facility uses the Centers for Medicare and Medicaid approved RAI manual regulations to determine the type and timing of MDS assessments. MDSN A could not produce a hard copy of the admission MDS assessment for Resident 123 and the Annual MDS assessments for Residents 14 and 126. MDSN A stated the MDS assessments for Residents 14, 123, and 126 were not completed and were overdue.

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	555281	A. Building B. Wing	05/08/2026

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete the Quarterly Minimum Data Set (MDS) assessment within 92 calendar days of the previous assessment for two of five sampled residents (Residents 11 and 12). This failure had the potential to delay the development of comprehensive care plans necessary to provide appropriate, individualized care and services for Residents 11 and 12.Findings:A review of Centers for Medicare & Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual, effective 10/1/25, indicates that Quarterly Review assessment must be completed no less frequently than every 92 days. The ARD for a quarterly assessment must be set no later than 92 days after the ARD of the previous assessment (Admission, Annual, or Quarterly).A review of Resident 11's clinical record indicated Resident 11 was admitted on [DATE] with diagnoses including diabetes type 2 (high blood sugar), restless legs, and hypertension (high blood pressure). Resident 11's most recent MDS assessment, dated 9/19/26, indicated the quarterly assessment was due by 5/3/26 and was five days overdue.A review of Resident 12's clinical record indicated Resident 12 was admitted on [DATE] with diagnoses including stroke, restless leg, and anxiety. Resident 12's most recent MDS assessment, dated 4/19/26, indicated the quarterly assessment was due by 5/3/26 and was five days overdue.During a concurrent interview and record review on 5/7/26 at 10:35 am, with MDS Nurses (MDSN) A and B, the MDSN B stated that Quarterly MDS assessments are required every three months or every 92 days. MDSN A stated that MDS assessments are Not always done in this time frame due to the facility's resident population, acuity, and frequent turnover.During a concurrent interview and record review on 5/7/26 at 12:01 pm, with MDSN A, the MDSN A stated the facility uses the RAI manual to determine the type and timing of MDS assessments. MDSN A could not produce a hard copy of the Quarterly Comprehensive MDS assessments for Residents 11 and 12 and confirmed that the Quarterly MDS assessments for Residents 11 and 12 were not completed and were overdue.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and a review of facility records, the facility failed to maintain adequate nursing staff to meet residents' care needs, when:1.Resident council meetings and resident grievances from January to May 2026 documented delays in staff response to call lights.2.Seven of twenty-four residents reported insufficient direct care staff, resulting in delayed responses to call lights and inadequate assistance with activities of daily living, including toileting, oral care, and pain management. 3.The facility did not take resident acuity (complexity and intensity of care needs) into account when scheduling Certified Nursing Assistant (CNA) staff for the [NAME] and North Nursing Stations.As a result of these staffing deficiencies, resident care needs were not consistently met. Residents expressed feelings of neglect and frustration due to delayed responses and unmet care preferences.Findings:1.A review of Resident Council meeting minutes and grievance forms revealed repeated concerns:On 01/21/2026, a resident commented, call light response times are too long, while another asked for help with preparing her toothbrush.On 01/23/2026, a resident reported waiting two hours and twenty-five minutes to be changed, leaving her feeling I do not matter.On 01/27/2026, a resident stated she was not changed for six hours, which occurred three times that week.On 02/21/2026, a resident noted she was not changed between 10:00 pm and 5:22 am.On 02/25/2026, a resident commented, we do not have enough CNAs.On 03/08/2026, a resident stated her incontinent brief was not changed for seven hours.On 04/29/2026, a resident indicated the facility needs more CNAs.During confidential interviews on 03/05/2026 at 02:15 pm, three out of five residents confirmed that staffing was insufficient and that this concern had been repeatedly raised in Resident Council meetings. All three agreed that the staffing issue remained unresolved.2. During interviews with residents:On 05/05/2026 at 08:55 am, Resident 7 described wounds causing constant pain and reported frequent waits of 30 minutes to two hours for pain medication, making pain management difficult and discouraging participation in daily activities.On 05/07/2026 at 02:58 pm, Resident 88 stated that staff did not honor her care preferences, such as timely delivery of coffee, which affected her sleep and increased her anxiety. She also felt rushed during showers.On 05/08/2026 at 08:55 am, Resident 2 expressed concern about inadequate staffing during both day and night shifts, specifically mentioning only two CNAs working on her hall and frequent delays for assistance, particularly at night.On 05/05/2026 at 10:25 am, Resident 93 reported wait times of up to two hours for brief changes and personal care, with delays occurring regardless of staff shift or gender.On 05/05/2026 at 11:05 am, Resident 59 described waiting up to thirty minutes after activating the call light, including while in the bathroom, causing her anxiety.On 05/06/2026 at 07:45 am, Resident 42 stated, sometimes it takes an hour to get my call light answered, noted many call lights ringing in the hall, and said staff complained about heavy workloads and high patient-to-staff ratios.On 05/06/2026 at 04:00 pm, Resident 95 reported inconsistent call light response times, sometimes waiting up to ninety minutes. He noted that delays led to accidents, especially after bladder surgery, and emphasized the need for more staff.3. During a concurrent interview and record review on 05/06/2026 at 3:10 pm, the facility Scheduler (SCH) explained the staffing patterns on the West, East, and North Nursing Stations from January to March 2026 schedules:Day shift: CNAs allocated based on census 4 CNAs West, 5 East, 2 North if census above 110-115; If census lower CNAs 3 West, 4 CNAs EAST, 2 CNAs North.Evening shift: 4 CNAs each on East and West, and 2 on North. When census low 3 CNAs on West, 4 CNAs on East and 2 on North.Night shift: CNAs 4 [NAME] and East and 2 CNAs North. When census low 3 CNAs East and [NAME] on both evening and night shift.SCH stated their scheduling process was mostly resident census driven not resident acuity, and the long-term care (East Nursing Station) gets more staff than short term side (West and North Station.) SCH stated they rely on CNAs to inform them if residents on a Nursing Station become dependent and they need more CNAs to assist.A review of a Resident Alert Tally report dated (continued on next page)

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	555281	A. Building B. Wing	05/08/2026

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/7/2026, had 20 dependent residents who required one-on-one staff feeding assistance for all meals. The report indicated:Seven residents on East Nursing StationEight residents on [NAME] Nursing StationFive residents on North Nursing Station A review of a facility weight entry report dated 03/12/2026, indicated a list of residents who required the use of a Hoyer lift for transfers. There was a total of 44 residents in the facility, 18 on the East Nursing Station, 13 on both the North/West Nursing Stations.During an interview on 05/05/2026 at 9:29 am, Licensed Nurse (LN G) stated staffing on days and evenings, were running short for Rooms in the 100's (West) and 300's (East). LN G stated residents have informed them they have been waiting for 30 minutes for staff assistance.During an interview on 05/06/2026 at 03:10 pm, with Director of Rehab Services (DRS) stated Restorative Nursing Assistants (RNAs, works with the physical therapy department) are pulled from their RNA duties when the facility needs to ensure resident are receiving necessary observation and direct resident care. During an interview with RNA C on 05/07/2026 at 10:58 am, RNA C stated at least one of the three days they worked this week, additional responsibilities were assigned beyond his RNA tasks. RNA C stated this affects their ability to complete his RNA tasks with residents. RNA C stated they were frequently pulled from RNA duties to provide one-on-one observation and direct resident care.During an interview on 05/08/2026 at 9 am, RNA D and RNA E confirmed they do get pulled from their RNA duties to assist with CNAs often. RNA D and E stated sometimes it happens days in a row then they have to speak up to remind administration that they have RNA work to complete. RNA D and RNA E stated East Nursing more dependent with Hoyer lift (a mechanical lifting device requiring 2 staff to transfer residents with limited mobility safely between from bed to wheelchair), residents with behaviors (requires increased supervision.) During an interview on 05/08/2026 at 09:10 am, CNA F stated the workload on [NAME] Nursing Station was heavier due to residents coming from the hospital.During an interview on 05/07/2026 at 09:30 am, SCH confirmed he does not consider resident acuity when scheduling, such as residents who require Hoyer lifts, who are dependent for dining assistance and residents who have behaviors. SCH stated he relies on information from the CNAs about the level of resident acuity. SCH stated CNA scheduling was mostly resident census driven and that they scheduled more CNAs on the long-term care nursing station (East) and scheduled more staff on the short term side (West).During an interview on 05/07/2026 at 10 am, the Director of Nursing (DON) confirmed there was no hospital-like system for determining resident acuity to guide sufficient staffing. DON acknowledged the absence of call light audits and a system to track resident call light complaints. DON confirmed administrative have not collected resident concerns through executive rounds (staff interview residents about concerns). DON confirmed staffing levels was not being addressed in the facilities Quality Assurance Performance Improvement program, although they had in the past.

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	555281	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oroville Hospital Post-Acute Center	1000 Executive Parkway Oroville, CA 95966

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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. Based on interview and record review the facility failed to ensure that one out of 24 sampled residents (Resident 46) was free from abuse when Resident 128 punched Resident 46 in the face.The incident resulted in a laceration to Resident 46's upper lip requiring stitches and caused temporary feelings of insecurity regarding personal safety. Findings: A review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation, and Misappropriation of Resident Property Prohibition, revised 7/15/21, indicated, residents had the right to be free from physical abuse.A review of Resident 46's admission Record, dated 9/1/24, indicated, admission to the facility on 9/1/24 with the diagnoses of anxiety (feelings of fear and worry) and personal history of traumatic brain injury (a head injury that caused impaired thinking). Resident 46 was not their own responsible party (RP, decision maker). A review of Resident 128's admission Record, dated 3/25/26, indicated, admission to the facility on 3/25/26 with the diagnosis of an unspecified mental disorder (the resident had a mental health condition but there was not enough information to determine a diagnosis). Resident 128 was their own RP. During an interview on 5/5/26 at 1:59 pm, with Resident 46, Resident 46 confirmed, on 3/28/26, Resident 128 punched Resident 46 on the face while exiting the [NAME] Wing dining room. Resident 46 stated, I was scared half to death. A review of the Interdisciplinary [group of facility staff] Note, dated 3/29/26, indicated, Resident 46 and Resident 128 were in an altercation, which resulted in Resident 46 sustaining a three-centimeter-long laceration to the left upper lip, requiring sutures (stiches) and an emergency room visit. The Interdisciplinary Note indicated, Resident 46 was provided with a one-on-one sitter (someone always stayed nearby) for safety concerns. During an interview on 5/8/26 at 9:09 am, with Assistant Director of Nursing (ADON), the ADON indicated, reviewing video surveillance of the resident-to-resident altercation that occurred on 3/28/26 and confirmed Resident 128 punched Resident 46 in the face. During an interview on 5/8/26 at 10:23 am, Resident 42 indicated, facility staff had provided extra monitoring and stated, I had fear he would come back and get me. Resident 42 indicated the fear had lasted for three or four days.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure that adequate dialysis (a life-saving medical treatment performed to filter toxins out of the blood) care and services were provided for one of one sampled resident (Resident 42), when: Required dialysis communication forms were missing and incomplete.Licensed Nurses did not perform and document daily assessments of the resident's dialysis fistula (the surgically created access used for dialysis).Resident 42's care plan (a document that described resident goals and the care that would be provided) did not include instructions describing the assessments required for monitoring the fistula. This failure had the potential to result in undetected, life-threatening complication. Findings: 1.A review of the facility's undated policy and procedure (P&P) titled, Dialysis, indicated, the facility and dialysis center would communicate with each other by utilizing the Dialysis Transfer Form. A review of Resident 42's admission Record, dated 1/4/25, indicated admission to the facility on 1/4/25 with the diagnoses of end stage renal disease (the kidneys [an organ that filtered waste from the blood] no longer functioned well enough to support life) and dependence on renal dialysis. Resident 42 was their own responsible party (decision maker).During a concurrent observation and interview on 5/6/25 at 7:45 am, located in Resident 42's room, Resident 42's right upper arm was observed and Resident 42 indicated, receiving dialysis three times a week, every Tuesday, Thursday, and Saturday. On 5/7/26 at 4:20 pm, a request was made to Medical Records for the last four months (2/1/26 through 5/7/26) of Resident 42's Dialysis Transfer Form. At 4:58 pm the same day, the forms provided were reviewed and found to be incomplete. Dialysis Transfer Forms for the periods 2/1/26 through 2/28/26 and 5/1/26 through 5/7/26 were missing. During a concurrent interview and record review on 5/8/26 at 8:41 am, with the Assistant Director of Nursing (ADON), the previously provided Dialysis Transfer Forms for the last four months were reviewed. The ADON confirmed that the forms dated 4/7/26 and 4/23/26 lacked a complete LN assessment of the resident's dialysis fistula. A second request for February and May's Dialysis Transfer Forms had been made. During a concurrent interview and record review on 5/8/26 at 11:22 am, with the ADON and the Director of Nursing (DON), additional Dialysis Transfer Forms were provided for review. The ADON confirmed that the additional forms did not include the required forms for February or May. The DON stated that the wrong months had been requested from the Medical Records department. The ADON further confirmed that, among the forms that were provided, the forms dated 3/14/26, 4/11/26, and 4/19/26 were missing. 2. A review of the facility's undated P&P titled, Dialysis, indicated, the facility Provides ongoing monitoring of the dialysis access site, observing for signs and symptoms of infection, edema [swelling], ischemia [lack of blood flow], bleeding and dislodgement. The P&P indicated, the LN would document the fistula assessment in the Medication Administration Record (MAR).During an interview on 5/6/25 at 7:45 am, located in Resident 42's room, Resident 42 stated, They don't listen to my fistula. The only people who listen are the student nurses. (part of the assessment of a fistula included placing a stethoscope on top of the fistula site to listen to the swishing sound called the bruit). During a concurrent interview and record review on 5/7/26 at 4:18 pm, with LN B, Resident 42's MAR dated 4/1/26 through 5/7/26 was reviewed. LN B confirmed that no assessments of Resident 42's dialysis fistula were documented during this period. LN B stated that the fistula should be assessed daily, including visual inspection, auscultation for a bruit, and palpation for a thrill, to ensure the access site was free from infection and functioning properly. During a concurrent interview and record review, on 5/8/26 at 11:22 am, with ADON, Resident 42's April and May MARs were reviewed. ADON indicated that Resident 42 received a fistula to the upper right arm on 3/31/26 and confirmed, since the fistula's placement, there were no LN assessments. 3. A review of the facility's undated policy and procedure (P&P) titled, Dialysis, indicated, the facility would develop a comprehensive plan of care for residents that received dialysis. During a concurrent interview and record review, on 5/8/26 at 11:22 am, with ADON, Resident 42's care plan, titled Dialysis, dated 10/27/25 was reviewed. ADON (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated, Resident 42 received the fistula on 3/31/26 and confirmed, the care plan was not updated to include assessing the fistula site daily.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure one out of five sampled residents (Resident 12) was free from unnecessary medications when the required psychotropic (a medication that altered the brain) medication informed consent form was not renewed every six months as required.This failure had the potential to compromise Resident 12's ability to maintain their highest practicable mental, physical, and psychosocial well-being.Findings: A review of the facility's undated policy and procedure titled, Informed Consent for Psychotropic Drugs, indicated the facility would follow Federal and State regulations regarding informed consent when the Physician prescribed a psychotropic medication. A review of the All Facilities Letter (an official document that notified facilities of changes to regulations), dated 10/7/25, indicated psychotropic informed consent forms were required to be renewed every six months. A review of Resident 12's admission Record, dated 11/3/20, indicated admission the facility on 11/3/20 with the diagnoses of chronic (long lasting) pain and major depressive disorder recurrent (feelings of deep sadness and hopelessness that comes and goes). A review of Resident 12's Order Listing Report, dated 11/20/22, indicated that on 11/20/22 the Physician prescribed Cymbalta (an anti-depressant medication that was also a psychotropic medication and was also used for pain management) 60 milligrams (mg, unit of measure), to be given by mouth one time a day for chronic pain. During a concurrent interview and record review on 5/7/26 at 9:31 am, with Assistant Director of Nursing (ADON), Resident 12's Psychotropic Drugs Disclosure and Consent form dated 11/27/22 was reviewed. The ADON confirmed the informed-consent form for Resident 12, who received Cymbalta 60 mg daily, was outdated and had not been renewed every six months as required.