STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555304	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Post Acute	1200 Springfield Drive Chico, CA 95928

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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555304	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Post Acute	1200 Springfield Drive Chico, CA 95928

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect one of three residents, sampled for abuse, (Resident 1) the right to be free from neglect due to the deprivation of goods and services by Licensed Nurse (LN) A when Resident 1 had pain in her broken right ankle and LN A indicated she was too busy to dispense Resident 1 pain medication. This resulted in Resident 1 experiencing unnecessary unrelieved pain and discomfort to right ankle and had the potential to negatively impact her physical and emotional well-being. FindingsA review of the facility's policy titled Identifying Types of Abuse revised 9/22, indicated abuse of any kind against residents is strictly prohibited. Abuse includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident requires but the facility fails to provide them and this has resulted in (or may result in) physical harm, pain mental anguish or emotional distress.A review of the facility's policy titled Resident Rights revised 2/20/21, indicated employees shall treat all resident with kindness, respect, and dignity and be free from abuse, neglect.A review of Resident 1's admission record indicated Resident 1 was admitted on [DATE] with diagnoses which included surgery to the right hip from a broken hip (due to a fall at home), dementia (a loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), Alzheimer's (a progressive disease that destroys memory and other important mental functions), osteoporosis (bones are weak and brittle), muscle weakness, and diabetes (high sugar in the blood). The admission record indicated Resident 1 did not have mental capacity to make healthcare decisions. A review of Resident 1's admission Minimum Data Set (MDS, a complete clinical assessment), dated 1/17/25, section C- Cognitive Patterns (determines residents attention, orientation, and ability to register and recall information) indicated Resident 1 had a Brief Interview for Mental Status (BIMS, an assessment used to evaluate memory and decision making skills on a scale of 0 to 15, with 0 being highly impaired and 15 being no impairment), Resident 1 scored 0 which indicated Resident 1's cognition was severely impaired. A review of Resident 1's progress notes dated 3/10/25 at 3:46 am, was conducted. Licensed Nurse (LN) B, documented that at 6:45 pm she found Resident 1 in her room between the bed and her room door, lying on her left side sitting halfway up with her hands holding her up on the floor, and indicated that it appeared as though Resident 1 may have been trying to walk to the restroom. LN B documented, her [Resident 1's] lateral [outside] [right] ankle was swollen and tender to touch. This nurse called MD [Medical Doctor] he ordered x-ray [to right ankle] to be done in the facility, Asper-creme (a cream that helps relieve joint pain and reduce swelling] to be applied topically [on top of the right foot], ace bandage wrap [an elastic bandage that reduces swelling], ice [to the right foot], and a foot cradle [a metal frame that goes on the foot of the bed to keep blankets and sheets from touching the feet] to keep the blanket off the foot since there is so much swelling and discoloration. FM also stated she wanted [Resident 1] to have consistent pain management with this COC [Change of Condition] this was endorsed [told to] to oncoming nurse. During an interview with Resident 1's family member (FM) on 6/10/25 at 9:44 am, FM stated she got a call from LN B on 3/9/25 in the evening, telling her that Resident 1 had fallen and hurt her right ankle. FM stated she came to the facility the next day, on 3/10/25 before lunch, and found that Resident 1's right ankle was causing her so much pain and that Resident 1 was crying. Resident 1's right foot and ankle were black and blue, swollen, and hurt when it was touched. FM stated she asked LN A if she had given Resident 1 any pain medication. LN A replied that she had not given Resident 1 any pain medication since she had come on shift at 6:30 am. FM stated that she asked the LN A to send Resident 1 to the hospital so her right foot could be evaluated and x-rayed. During a concurrent interview with Physical Therapist and record review on 7/11/25 at 2:51 pm, Resident 1's therapy notes were reviewed for a session dated 3/10/25 at around 11:00 am. PT notes indicated Response to Session interventions: the patient recently suffered a ground level fall last night and her R [right] lower leg was involved. The patient was approached in bed and the patient was very lethargic. The patient endorses [states] large amounts of pain in her RLE [right lower extremity] and is very tender to palpation on the outside of the ankle and displays large area of bruising and diffuse swelling throughout. PT stated that when he went in to do Resident 1's therapy on 3/10/25 around 11:00 am, he remembered Resident 1 being in pain. Resident 1 had a purple

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555304	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Post Acute	1200 Springfield Drive Chico, CA 95928

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555304	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Post Acute	1200 Springfield Drive Chico, CA 95928

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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three residents sampled for falls with injury was provided with the necessary care to prevent an avoidable fall with injury (Resident 1) when the facility failed to;1.Take Resident 1 to the bathroom on 3/9/25, after her family member (FM) told staff that she needed to go. Subsequently, Resident 1 got up on her own to use the bathroom and fell. This failure to toilet Resident 1 resulted in Resident 1 falling and sustaining a broken right ankle, foot and toes which caused her severe pain, a transfer to the hospital, and delayed her discharge back home by 6 weeks. (Refer to F600 and F697)2.Ensure Resident 1 was assigned a Certified Nursing Assistant (CNA) to take care of her on the PM shift (2:30 pm to 11 pm), on 3/9/25.This failure resulted in Resident 1 having no CNA assigned to her care and help her to the bathroom and Resident 1 fell and sustained a broken ankle, foot and toes.3.Review and revise Resident 1's care plan with new interventions to prevent further falls and injuries on 3/6/25.This failure resulted in Resident 1 having another fall three days later. Findings:1.The facility's policy titled, Falls and Fall Risk, Managing revised March 2018, was reviewed and indicated, based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant.A review of Resident 1's admission record indicated Resident 1 was admitted on [DATE] to nursing unit three (rooms 300 thru 317), with diagnoses which included surgery to the right hip from a broken hip (due to a fall at home), dementia (a loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), Alzheimer's (a progressive disease that destroys memory and other important mental functions), osteoporosis (bones are weak and brittle), muscle weakness, and diabetes (high sugar in the blood).A review of Resident 1's January 2025 Physician's Orders indicated:a An order, dated 1/30/25, indicated Resident 1 did not have capacity to understand choices, to make health care decisions and/or participate in a treatment plan. Resident 1's Family Member (FM) was Resident 1's decision maker. b An order, dated 1/15/25, for Norco (narcotic pain pill) tablet 5-325 mg (milligram a unit of measurement), give one tablet by mouth every four hours as needed (PRN) for pain level 4-6 (moderate pain) and a Norco tablet 10-325 mg, give one tablet by mouth every four hours as needed for pain level 7-10 (severe pain).A review of Resident 1's admission Minimum Data Set (MDS, a complete clinical assessment), dated 1/17/25, section C- Cognitive Patterns (determines residents attention, orientation, and ability to register and recall information) indicated Resident 1 had a Brief Interview for Mental Status (BIMS, an assessment used to evaluate memory and decision making skills on a scale of 0 to 15, with 0 being highly impaired and 15 being no impairment), and Resident 1 scored 0, which indicated Resident 1's cognition was severely impaired. Section GG- Functional Abilities and Goals indicated Resident 1 required maximal assistance (Staff does most of the work) from staff for bed mobility (to turn and reposition in bed), transferring from chair to bed and bed to chair, and was dependent (staff does all of the work) on staff for toileting (going to the bathroom). Section H- Bladder and Bowel indicated Resident 1 had occasional urinary incontinence (some loss of bladder control) episodes and was always continent (had full control) of her bowels.A review of Resident 1's admission Fall Risk Assessment, dated 1/14/25, indicated that Resident 1 was at high risk for falls with a score of 22 based on Resident 1's cognition, previous history of falls, bowel and bladder continence (control), and medications she was taking.A review of Resident 1's care plans was conducted and indicated the following: a Musculoskeletal Care Plan, dated 1/14/25, included interventions to Anticipate and meet needs. respond promptly to all requests for assistance.b High Risk for Fall Care Plan, revised 2/11/25, included interventions to anticipate and meet needs, keep within supervised view as much as possible, keep bed in low position with brakes locked, keep call light within reach.c. Bladder Incontinence Care Plan, dated 1/14/25, included interventions to offer toileting on rounds (an every two hour check done by the CNAs), upon request, and as needed.During a phone interview with FM on 6/10/25 at 9:44 am, FM stated, Right before I left [the facility] that day [3/9/25] at about 6:15 pm, I told the nurse [Licensed Nurse A] that [Resident 1] was laying down to go to sleep but you will have to get her up and take her to the bathroom or she would try to go to the bathroom by herself. [LN A] responded okay. FM stated that around 6:50 pm, (40 minutes later), that same evening (3/9/25), FM received a call from the facility that Resident 1 had fallen trying to go to the bathroom. FM stated that 6:30 pm was Resident 1's usual time to go to the bathroom and get ready for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555304	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Post Acute	1200 Springfield Drive Chico, CA 95928

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555304	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Post Acute	1200 Springfield Drive Chico, CA 95928

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure pain management was provided for one of three residents sampled for pain management (Resident 1) when Resident 1 had pain in her right ankle rated at a 5 (on a pain scale from 0-10 with 0 being no pain and 10 being severe pain) and was not medicated with pain medication as indicated in her physician's orders consistent with her pain level.This resulted in Resident 1 experiencing unrelieved moderate pain and tenderness to right ankle and had the potential to negatively impact her physical and emotional well-being.Findings:A review of the facility's policy titled, Pain Assessment and Management dated April 2025, indicated, The purpose of this procedure is to help the staff identify pain in the residents, and to develop interventions that are consistent with resident needs. Possible Behavioral Signs of pain: Facial Expression such as grimacing, frowning, clenching of jaw. Implement the medication regimen per Physician orders.A review of the facility's policy titled, Pain-Clinical Protocol Revised April 2025, indicated, The physician and staff will identify individuals who have pain or who are at risk for having pain.A review of the facility's policy titled, Administering Pain Medications revised April 2025, indicated, The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. Pain Management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. Pain management is a multidisciplinary process that includes the following: a. identifying signs and symptoms of and assessing existing pain; b. recognizing situation and conditions with the potential for pain.f. monitoring for the effectiveness of interventions; and g. modifying approaches as necessary.A review of Resident 1's admission record indicated Resident 1 was admitted on [DATE] with diagnoses which included surgery to the right hip from a broken hip (due to a fall at home), dementia (a loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), Alzheimer's (a progressive disease that destroys memory and other important mental functions), osteoporosis (bones are weak and brittle), muscle weakness, and diabetes (high sugar in the blood). The admission record indicated Resident 1 did not have mental capacity to make healthcare decisions. A review of Resident 1's admission Minimum Data Set (MDS, a complete clinical assessment), dated 1/17/25, section C- Cognitive Patterns (determines residents attention, orientation, and ability to register and recall information) indicated Resident 1 had a Brief Interview for Mental Status (BIMS, an assessment used to evaluate memory and decision making skills on a scale of 0 to 15, with 0 being highly impaired and 15 being no impairment), Resident 1 scored 0 which indicated Resident 1's cognition was severely impaired. A review of Resident 1's progress notes dated 3/10/25 at 3:46 am, was conducted. Licensed Nurse (LN) B, documented that at 6:45 pm she found Resident 1 in her room between the bed and her room door, lying on her left side sitting halfway up with her hands holding her up on the floor, and indicated that it appeared as though Resident 1 may be have been trying to walk to the restroom. LN B documented, her [Resident 1's] lateral [outside] [right] ankle was swollen and tender to touch. This nurse called MD [Medical Doctor] he ordered x-ray [to right ankle] to be done in the facility, Asper-creme (a cream that helps relieve joint pain and reduce swelling] to be applied topically [on top of the right foot], ace bandage wrap [an elastic bandage that reduces swelling], ice [to the right foot], and a foot cradle [a metal frame that goes on the foot of the bed to keep blankets and sheets from touching the feet] to keep the blanket off the foot since there is so much swelling and discoloration. FM also stated she wanted [Resident 1] to have consistent pain management with this COC [Change of Condition] this was endorsed [told to] to oncoming nurse. During an interview with Resident 1's family member (FM) on 6/10/25 at 9:44 am, FM stated she got a call from LN B on 3/9/25 in the evening, telling her that Resident 1 had fell and hurt her right ankle. FM stated she came to the facility the next day, on 3/10/25 before lunch, and found that Resident 1's right ankle was causing her so much pain. Resident 1's right foot and ankle were black and blue, swollen, and hurt when it was touched. FM stated she asked LN A if she had given Resident 1 any pain medication. LN A replied that she had not given Resident 1 any pain medication since she had come on shift at 6:30 am. FM stated that she asked the LN A to send Resident 1 to the hospital at that point, so her right foot could be evaluated and x-rayed. A review of Resident 1's progress notes dated 3/10/25 at 1:27 pm, was conducted. LN A documented Resident's right ankle was swollen, purple, and wrapped in an ace wrap. LN A documented that Resident 1 had an X-ray taken of her right ankle and foot on 3/10/25 at 10:00 am, in the facility and that