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	02/04/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations, interviews, and record reviews, the facility failed to accommodate the needs for one out of two sampled residents (Resident 1) when bed canes (a device that was like a grab bar, attached to the bed, and designed to help residents move, reposition, or transfer out of bed) were recommended and not provided in a timely manner. This failure caused Resident 1 to depend upon staff for bed mobility (movement) and had the potential to cause a decline in maintaining and/or achieving independent functioning, dignity, and well-being.Findings: A review of the facility's policies and procedures titled, Assistive Devices and Equipment, dated 2/1/21, indicated it provided assistive devices to help residents with mobility and independence. A review of Resident 1's admission Record, dated 1/13/26, indicated, admission to the facility on 1/13/26 with the diagnoses of Parkinson's Disease (incurable brain disorder that affected movement of the body), essential tremor (involuntary shaking, most commonly in the hands), and muscle weakness. Resident 1 was their own responsible party (made own decisions). A review of the admission Minimum Data Set (MDS, an assessment tool), Section C, dated 1/19/26, indicated a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was conducted. Resident 1 scored 12 out of 15, indicating intact memory. A review of the admission MDS, Section GG, dated 1/20/26, indicated that Resident 1 had limited function of both legs, required touching assistance to roll over in bed, and required moderate assistance to sit up in bed. A review of Resident 1's care plan (a written document that contained resident goals and care instructions for staff) titled, ADL/Mobility (activities of daily living, dressing, showering, getting in and out of bed), dated 1/13/26, indicated that Resident 1 was at risk for a decline with ADLs and mobility and facility staff would encourage Resident 1 to participate in ADLs to promote independence. During an observation on 1/29/26 at 2:25 pm, Resident 1's bed was observed. There were no bed canes or bed rails present. During an observation on 2/4/26 at 9:28 am, Resident 1's bed was observed. There were no bed canes or bed rails present. During a concurrent observation and interview on 2/4/26 at 9:29 am, with Certified Nurse Assistant (CNA) A, Resident 1's bed was observed. CNA A confirmed, there were no bed canes present and stated, Resident 1 can turn in bed with one person assistance. During a concurrent observation and interview on 2/4/26 at 9:48 am, Resident 1 stated, We've talked a lot about the bed rails [bed canes]. I need the bed rails to hold to help pull myself around. Resident 1 was asked if he was dependent upon staff for bed mobility due to not having bed canes or bed rails and stated, quite a bit. During the interview, Resident 1 utilized the call light and requested assistance from CNA A to use the bathroom. CNA A was observed asking Resident 1 to roll in bed towards CNA A. Resident 1 stated, I can't, I have nothing to hold on to. CNA A was observed assisting Resident 1 to roll from a back laying position to a side laying position. During a concurrent interview and record review on 2/4/26 at 10:06 am, with Licensed Nurse (LN) B, Resident 1's Bed Rail and Entrapment Risk Observation/Assessment (bedrail consent form), dated 1/13/26 was reviewed. LN B confirmed the bedrail consent indicated that a (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendation had been made for Resident 1 to have bed canes due to mobility limitations. LN B confirmed Resident 1 was dependent upon staff for bed mobility and Resident 1's bed did not have bed canes. LN B stated, there are a few beds in the facility that don't accommodate bed rails or bed canes. During a concurrent interview and record review on 2/4/26 at 10:49 am, with Maintenance Director (MD), a work order, dated 1/31/26 was reviewed. MD confirmed the work order indicated a request for Resident 1 to have bed rails was made on 1/31/26 (18 days after the facility assessed Resident 1's need for bed canes). MD stated, Resident 1's bed doesn't accommodate bed canes, and a work order was submitted for bed canes. MD confirmed, there was no available bed in the facility to accommodate the use of bed canes and stated, the facility was at max capacity (the facility had reached maximum capacity for residents and there were no more beds). During an interview on 2/4/26 at 11:58 am, LN C indicated, when a resident was assessed upon admission, it included an assessment for bed canes. LN C stated, if they have a need, it goes to maintenance, we ask maintenance for the bed to be assessed. LN C indicated the bed assessment was to determine if the bed was compatible with the use of bed canes. LN C confirmed, Resident 1's bed did not have bed canes and was not able to verbalize why. During an interview on 2/4/26 at 12:28 pm, Director of Nursing (DON) stated, the admission nurse (LN C) does the assessment (Bed Rail and Entrapment Risk Observation/Assessment), if LN C feels it's appropriate, LN C puts in the work order. DON confirmed, the assessment occurred on 1/13/26, the work order for Resident 1's bed canes was entered 1/31/26, and Resident 1 did not have bed canes attached to the bed. DON stated, Resident 1's bed doesn't accommodate [the use of bed canes], we are full [facility was at maximum resident capacity], it's an equipment issue, we don't have a bed to swap it out for. DON confirmed, Resident 1 needed bed canes and they were not provided.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on observations, interviews, and record reviews the facility did not ensure Physician ordered services were provided to one out of two sampled residents (Resident 1) when specialized rehabilitative services (expert led therapy program to help individuals improve on daily function and return to normal life) were not provided. This had the potential for Resident 1 not to attain or maintain their highest practicable level of physical, mental, functional, and psychosocial well-being.Findings: A review of the facility's policies and procedures (P&P) titled, Physician Orders, dated 10/1/24, indicated, treatment orders would be carried out in accordance with the Physician's order. A review of the facility's P&P titled, Speech Therapy, dated, 5/1/13, indicated, The purpose of this procedure is to identify, assess, and treat speech and language problems, including swallowing disorders (the specialist who performed this procedure was a Speech Therapist, ST). A review of Resident 1's admission Record, dated 1/13/26, indicated, admission to the facility on 1/13/26 with the diagnoses of essential tremor (involuntary shaking, most commonly in the hands), dysphagia oropharyngeal phase (swallowing problem that occurred in the mouth or throat), and cognitive communication deficit (an impairment in communication). Resident 1 was their own responsible party (made own decisions). A review of the admission Minimum Data Set (MDS, an assessment tool), Section C, dated 1/19/26, indicated a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was conducted. Resident 1 scored 12 out of 15, indicating intact memory. A review of the admission MDS, Section K, dated 1/20/26, indicated that Resident 2 had difficulty or pain when swallowing. During a concurrent interview and record review on 1/29/26 at 3:06 pm, with Director of Rehab (DOR), Resident 1's Physician's Order, dated 1/14/26 was reviewed. DOR confirmed the order indicated that ST performed an evaluation and Resident 1 required ST services, three times a week for four weeks. DOR reviewed Resident 1's Speech Therapy Evaluation and Plan of Treatment (the evaluation was the first visit and was utilized to develop a plan of care and treatment schedule), dated 1/14/26 and stated, we have not had him on the ordered schedule, he has only been seen that one time. A review of Resident 1's care plan (a detailed plan that included resident goals and facility staff care instructions) titled, Cognitive Communication Deficit, dated 1/14/26, indicated, ST would provide skilled treatments, three times a week for 4 weeks that included voice exercises, breathing exercises, group treatment, speech and hearing. The care plan indicated, Resident 1's goal was to improve functional skills to return home safely. During a concurrent observation and interview on 2/4/26 at 9:48 am, Resident 1 was observed laying in bed and their hands were shaking. Resident 1 was asked if the facility's ST had been providing treatments and Resident 1 stated, I thought she was going to work with me on speech and confirmed ST had performed the evaluation and no other visits were provided. Resident 1 spoke slowly and stopped speaking in between words with a look on his face that indicated he was thinking. During a concurrent interview and record review on 2/4/26 at 11:13 am, with Regional Director of Therapy Services (RDTS), Resident 1's Speech Therapy Evaluation and Plan of Treatment, dated 1/14/26 was reviewed. RDTS stated the ST evaluation indicated that Resident 1 required more assistance with speech therapy for speech function than with swallowing. RDTS confirmed, ST had performed an evaluation, ordered a visit frequency of three times a week for four weeks and did not provide any visits per the Physician's ordered visit frequency.