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	01/24/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49418 Based on observation, interview, and record review, the facility failed to ensure all residents were treated with dignity and respect by direct care staff during activities of daily living for two out of five sampled residents when: 1. Resident 44's room door and privacy curtains were open, exposing her back and chest. 2. Resident 68 did not receive assistance with toileting and a request for a food preference at breakfast. This resulted in Resident 44's privacy and dignity to be violated and Resident 68 felt cold and uncomfortable. Findings: A review of the facility's Policy and Procedure (P&P) titled Dignity, dated 8/2024, indicated: 1. Residents shall be treated with dignity and respect at all times. 2. Residents shall be encouraged to dress in their own clothes daily. 3. If resident's preference is limited or no clothing, the preference will be respected if (a) the preference is care planned and (b) the resident has appropriate coverage or privacy, for example, use of bed linens or closure of the privacy curtains. 4. Staff shall promote, maintain, and protect resident privacy, including bodily privacy, during assistance with personal care and during treatment procedures. 5. The residents individual needs, preferences and dignity shall be accommodated to the extent possible or when practicable and except when the health and safety of the individual or other residents would be endangered. A review of the facility's P&P titled Resident Rights, dated 10/2023, indicated federal and state laws guarantee certain basic rights to all residents of this facility, including: (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	01/24/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. A dignified existence, 2. To be treated with respect, kindness, and dignity, and 3. Privacy and confidentiality. A review of Resident 44's Admission Record indicated Resident 44 was admitted on [DATE]. Resident 44's diagnoses included morbid (severe) obesity, lack of coordination, generalized muscle weakness, reduced mobility (ability to move), major depressive disorder (a mental health condition that involves persistent feelings of sadness, hopelessness, and loss of interest in activities), and chronic obstructive pulmonary disease (COPD - a condition that constricts the airways and makes it difficult and uncomfortable to breathe). Resident 44 had a Brief Interview for Mental Status (BIMS) score of 14 on a scale of 0-15 on 11/12/24, indicating cognition (mental function) was intact. A review of Resident 44's Care Plan, dated 1/23/25, indicated Resident 44 prefers to lay in bed throughout the day (initiated 7/11/24, revised 1/16/25). The care plan indicated Resident 44 had two open areas on the left breast with treatment as ordered (initiated 1/18/25). Resident 44's clothing preferences were not documented in the Care Plan. During concurrent observation and interview in Resident 44's room on 1/21/25 at 10:40 am, Resident 44 was observed lying on her left side in bed with a facility gown over her abdomen but below the breasts. The door of the room was open and the privacy curtain tied back, which exposed Resident 44's back and right breast to passersby and to her roommate. Resident 44 pressed her call light to request help with repositioning, and two Certified Nursing Assistants (CNAs), arrived to assist Resident 44. Upon entry into the room, CNA P stated, Let's cover your bits. Your [NAME] and crannies are showing. CNA P then covered Resident 44 with a blanket. On questioning, CNA P acknowledged Resident 44 had a right to privacy and that it was not okay that her body was exposed with the door and privacy curtains open. During an interview with Resident 44 on 1/24/25 at 8:14 am, Resident 44 stated the wound nurse would lay a gown over her top half after wound treatment but did not always cover her with blankets. Resident 44 stated she doesn't like her back to be uncovered with the door open because people can see in my room. 51253 2. A review of Resident 68's Admission assessment dated [DATE], indicated Resident 68 was admitted for bilateral (right and left) osteoarthritis of knee, morbid obesity, chronic respiratory failure, and muscle weakness. A review of a Minimum Data Set (MDS, resident assessment) dated 10/10/24, indicated under the section functional abilities that the activity of toilet transfer (ability to get on and off toilet) and walking was not attempted by Resident 68. A review of an Activity of Daily Living care plan dated 10/25/24, indicated Resident 68 required one to two staff persons to assist with toilet use and required two person or mechanical lift to transfer her. (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	01/24/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Check and Change care plan dated 1/8/25, indicated Resident 68 uses a bed pan (device to collect uring while lying or sitting in bed) uses it herself and staff assist her off the bed pan and change her incontinence brief if needed. The goals were to have decreased incontinence and she will maintain comfort and dignity. During an interview of Resident 68 on 1/21/25 at 8:48 am, Resident 68 stated some staff do not help her. Resident 68 stated that she has bouts of incontinence in the night and she wakes up wet and cold. Resident 68 explained she uses the bed pan independently and sometimes the urine spills out on to the sheet and on the blanket. Resident 68 has requested for help, and Licensed Nurse (LN Q) and some of the other staff tell her to do it yourself. Resident 68 stated she was unable to get up on her own to help herself to the bathroom and required staff assistance. Resident 68 stated she feels cold and uncomfortable. During an interview of CNA M on 1/21/25 at 3:45 pm, CNA M stated Resident 68 can get up and go to the bathroom whenever she wants by herself. CNA M stated that Resident 68 was perfectly capable of cleaning herself. CNA M stated she did not need to get Resident 68 out of bed because she can get up on her walker and do it herself. During an interview of LN Q on 1/22/25 at 8:13 am, LN Q stated Resident 68 had night-time incontinence when she slept. LN Q stated Resident 68 was fully capable of cleaning herself. LN Q stated she does not need to help Resident 68 after soiling herself in bed. During an observation on 1/22/25 at 8:24 am, CNA O was bringing breakfast to Resident 68 and she requested a biscuit (on the menu for breakfast) with her gravy instead of an English muffin. Resident 68 explained the English muffin was hard to cut. CNA O stated you have one on your plate. CNA O engaged in an argument with Resident 68 and both voices were raised at each other. CNA O did not honor Resident 68's meal request. LN Q was observed standing at the door and did not intervene and stated, You can hear Resident 68 going off on that poor CNA. During an interview on 1/24/25 at 11:32 am, Director of Nursing (DON) was informed of the observed interaction between CNA O and Resident 68 who requested a biscuit for breakfast on 1/22/25. DON confirmed direct staff should treat all residents who requested assistance dignified and honored. DON stated it was disrespectful to argue loudly with Resident 68. DON confirmed Resident 68 should receive help when she asks for it regardless of her abilities. During an interview on 1/24/25 at 12:02 pm, Director of Staff Development (DSD) confirmed that Resident 68 was dependent on staff for activities of daily living. DSD confirmed that telling Resident 68 to do it yourself when she requested help with ADLs, was a lack of accommodation and not acceptable.

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	01/24/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on observation, interview, and record review, the facility direct care staff failed to place the call light within reach for two of four sampled residents, (Resident 39 and Resident 87). This failure had the potential for resident specific needs and requests to not be met in a timely manner, and the potential for negative clinical outcomes to include the potential for a fall. Findings: A review of the facility's policy revised 10/2024, titled, Answering the Call Light, indicated the purpose of this procedure is to respond to the resident's requests and needs. General guidelines include explain the call light to the new resident, demonstrate the use of the call light, be sure the call light is plugged in, and when the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident as much as practicable. 1. During a review of Resident 39's medical record, the Admission Record, indicated Resident 39 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (progressive brain disorder that causes uncontrollable movements), dysphasia (difficulty swallowing), heart disease, dementia (decline in mental ability such as thinking, remembering, and reasoning that affect activities of daily life), and depression (persistent feelings of sadness and loss of interest in activities). A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) dated 11/07/24, indicated that Resident 39 had a Brief Interview for Mental Status, (BIMS) score of 00 out of 15 which indicated Resident 39 was not able to complete the interview and had a severe cognitive deficit (ability to think and reason). This MDS also indicated Resident 39 required substantial/maximum assistance with all activities of daily living (ADLs, personal care tasks, dressing, toileting, bathing, hygiene, transfers, eating). During a review of Resident 39's medical record, a record dated 11/22/24, titled, Care Plan, indicated Resident 39 has an ADL/mobility deficit requiring extensive staff assistance with all ADLs related to Parkinson's disease. One of the interventions listed for Resident 39 indicated to encourage Resident 39 to use the call light for assistance. During an observation on 1/21/25 at 8:53 am, Resident 69's call light was not within reach while she was lying in bed. The call light was on the floor, and Resident 69 could not reach the call light to use for assistance if needed. During a concurrent observation and interview on 1/21/25 at 8:58 am, Resident 69 stated, I usually don't use the call light, but I can use it if I can reach it. Resident 69 demonstrated correct use of the call light once it was put in reach close to her hands while in bed. During an observation on 1/23/25 at 7:53 am, Resident 69's call light was not within reach, lying on the floor beside the bed. (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	01/24/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/25 at 7:57 am, Certified Nursing Assistant (CNA) Q confirmed the call light for Resident 69 was in the floor, out of reach for use and placed the call light in the bed for Resident 69. 2. During a review of Resident 87's medical record, the Admission Record, indicated Resident 87 was admitted to the facility on [DATE] with diagnoses that included a Cerebral Vascular Accident (stroke), difficulty walking, heart disease, unsteadiness on feet, and unspecified lack of coordination. A review of the most recent MDS dated [DATE], indicated that Resident 87 had a Brief Interview for Mental Status, (BIMS) score of 3 out of 15 which indicted a severe cognitive impairment. This assessment also indicated Resident 87 needed minimum assistance for ADLs. During a review of Resident 87's medical record, a record dated 1/7/25, titled, Care Plan, indicated Resident 87 is at risk for falls related to deconditioning. Two of the interventions listed for Resident 87 indicated to keep the call light within reach for Resident 87 to use the call light for assistance and use reminder sign to encourage the use of the call light. During an observation on 1/23/25 at 8:12 am, the call light for Resident 87 was lying in the floor, and resident was in bed with eyes closed resting, unable to reach the call light if needed. A sign was posted over Resident 87's bed that indicated, Reminder, call for assistance and do not fall. During an interview on 1/23/25 at 8:15 am, CNA A confirmed the call light was not within reach for Resident 87, and the call light was lying on the floor. CNA A stated, Yes, we help [Resident 87] to the bathroom and out of bed, she is a fall risk. During an interview on 1/23/25 at 8:55 am, the Director of Staff Development (DSD) confirmed the importance of all call lights being within reach for resident use. DSD stated, [Resident 87] is a fall risk, we have a sign over her bed to remind her to use the call light, she can walk with assistance. :

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	01/24/2025

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 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** 32797 Based on observation, interview and record review the facility failed to ensure the environment was maintained in a safe, clean, comfortable and homelike manner when: 1. Resident 5's mattress was uncomfortable. 2. Resident shower rooms had broken tiles, the showers and dining room was cold, and room [ROOM NUMBER]'s heater/AC unit had metal tape around it with exposed wall and insulation. This had the potential for residents to feel uncomfortable in their home. Findings: 1. During a concurrent observation and interview on 1/21/25 at 9:51 am, Resident 5, admitted [DATE], in room [ROOM NUMBER] B explained her mattress has hole in the middle of it. Resident 51 stated, I have told everyone I can think of since I have been here. Resident 51 stated if, I get stuck in the hole too long it's just uncomfortable. Resident stated that mattresses have been ordered and they have not come in yet. During an interview on 1/23/25 at 10:15 am, Central Supply (CS) stated they ordered four mattresses on 1/8/25, they arrived last week, and there are three still available. 2. A review of a facility policy titled, Comfortable and Safe Room Temperature Level Policy reviewed October 2024, indicated the purpose was to provide safe and comfortable room temperatures to assure optimal health and comfort of residents. The facility room temperatures should be between 71-81 degrees Fahrenheit (F). During a concurrent observation and interview on 1/22/25 at 8:45 am, Housekeeper (HSK) confirmed that in Shower room [ROOM NUMBER] near Station 1 and 2, was 69 degrees F. There was one heater at the entry of the shower room in the ceiling that was not connected to a thermostat. HSK explained CNAs have to turn it on to warm all the shower rooms. HSK confirmed at 8:50 am, Shower room [ROOM NUMBER] between Station 2 and 3 the temperature was 70 degrees F. During a concurrent observation and interview on 1/22/25 at 9:25 am, Activity Assistant (AA) confirmed the temperature in the main dining room was 67 degrees F. AA stated they have to turn it on, it is not automatically programmed. (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	01/24/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/24/25 at 8:10 am, the Maintenance Director (MND) and Maintenance Assistants (MDA and MDB) explained they do not have a facility log for checking temperatures in the shower rooms on Station 1, 2 and 3. MND, MDA, and MDB were all aware that the main dining room main was cold, 67 degrees F, and explained the thermostat was not programmable. They all confirmed that facility staff have to adjust the temperatures when entering the dining room and showers, no way to keep a consistent temperature. MND stated it the quality committee was planning to redo all the shower rooms due to the broken tiles on the floors, which they tried to paint and now was peeling off. MDB took the temperatures in all Shower rooms [ROOM NUMBER], all rooms were between 62-64 degrees F, and confirmed that had not met the regulation. MDB confirmed room [ROOM NUMBER] air conditioner/heater split unit was replaced, and they did not finish to cover the exposed wall and insulation. MDA and MDB stated they do environmental rounds weekly, and confirmed they have projects that are not finished in the facility and are working on a better system of tracking maintenance work.

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	01/24/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49418 Based on interview and record review, the facility failed to protect the rights of one of four sampled residents' (Resident 22) to be free from sexual abuse when Resident 120 was observed by staff to hold Resident 22's hand in his unzipped pants. This failure placed all residents at risk for potential sexual abuse and/or mental anguish from Resident 120. Findings: A review of facility Policy and Procedure (P&P) titled Resident Rights, dated 10/2023, indicated federal and state laws guarantee certain basic rights to all residents of this facility, including: 1. A dignified existence, 2. To be treated with respect, kindness, and dignity, and 3. To be free from abuse, neglect, stolen property, and exploitation (treating someone unfairly for one's own benefit). A review of facility P&P titled Abuse, Neglect, Exploitation, and Misappropriation (stealing) Prevention Program, dated 8/2024, indicated residents have the right to be free from abuse - including but not limited to the freedom from verbal, mental, sexual, or physical abuse - by anyone: staff, other residents, family members, visitors and any other individual. The P&P indicated the facility will: 1. Establish and maintain a culture of compassion and caring for all residents, particularly those with behavioral, cognitive, or emotional problems. 2. Provide staff training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, and stress management. 3. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or stolen resident property. 4. Investigate and report any allegations within timeframes required by federal requirements. 5. Protect residents from any further harm during investigations. A review of Resident 22's medical records indicated Resident 22 was admitted on [DATE] with diagnoses of dementia (a chronic condition causing decline in thinking, memory, and reasoning skills), anxiety disorder (a mental health condition characterized by excessive fear or apprehension of real or perceived threats), transient cerebral ischemic attack (TIA - a mini stroke, occurring when blood flow to the brain is briefly cut off), and major depressive disorder (a mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities). (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	01/24/2025

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	A review of Resident 22's Active Orders, dated 8/21/24, indicated Family Member 1 (FM 1) was Resident 22's surrogate decision maker because she did not have the mental capacity to understand choices, to make her own healthcare decisions, and/or participate in her treatment plan. This indicated Resident 22 did not have the mental capacity to consent to sexual contact. A review of Resident 22's Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated 12/20/24, indicated a score of 3 on a scale of 0-15 or severe cognitive impairment (a decline in mental function making it difficult to learn, remember things, and make her own decisions). This indicated Resident 22 did not have the mental capacity to consent to sexual contact. A review of Resident 120's medical records indicated Resident 120 was admitted on [DATE] with diagnoses of dementia, unspecified intracranial injury (brain damage) with loss of consciousness of unspecified duration, anxiety disorder, major depressive disorder, and affective mood disorder (a mental health condition that involves extreme mood swings and disruptions). A review of Resident 120's BIMS, dated 12/18/24, indicated a score of 9 out of 15, or moderate cognitive impairment. A review of Entity Reported Incident Intake Information, received at California Department of Public Health on 7/3/25 at 4:57 pm, indicated Resident 120 grabbed [female resident's] private area. They were separated and monitored. A review of Resident 120's Care Plan, dated 1/24/25, indicated: 1a. Psychosocial - Behavior: [Resident 120] exhibits behaviors of touching other female residents in groin area or placing female resident hand on his groin area, initiated 7/3/24, revised 11/1/24. 1b. Goals: Will respond to early interventions influencing the alterability (ability to change) of behaviors, initiated 7/3/24, target date 3/18/25. Will not have any incident of this behavior through review date, initiated 7/3/24, revised 11/1/24, target date 3/18/25. 1c. Interventions: i. Activities assessment for diversional activities, administer medication as ordered, anticipate needs and meet promptly, observe and document changes in behavior including frequency of occurrence and potential triggers, initiated 7/3/24. ii. Group activities this resident will not sit next to female residents to avoid behavior (sic), initiated 11/1/24. 2a. Sexual Activity: [Resident 120] exhibits [x] inappropriate sexual behavior towards female staff and female residents, attempts to touch females inappropriately, sexual comments made to female staff, initiated and revised 10/24/24. 2b. Goals: Will not act on sexually inappropriate impulses and Will not experience adverse health problems or injury related to sexual activity, initiated 10/24/24, target date 3/18/25. (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	01/24/2025

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	2c. Interventions: Activities assessment for diversional activities, administer medication as ordered, distract and direct as needed, monitor for signs of complications related to sexual activity (infection, injury) and notify physician if observed, notify physician and responsible party as indicated, resident has been educated about safe sex practices including prophylactic measures, Social Services as indicated, and visual deterrent to aid in reduction of attempts at inappropriate sexual activity, all initiated 10/24/24. 3. Cognition: Resident 120 has impaired cognitive function/dementia or impaired thought processes related to diagnosis of dementia, revised 2/19/24, with interventions including cue, reorient and supervise as needed, initiated 2/19/24. Review of a letter from facility Administrator (Admin) to State Agency (SA), dated 10/29/24, indicated: 1. Activities Assistant B (AA B) observed Resident 120 holding Resident 22's hand inside his unzipped pants over his brief (adult diaper) during an ice cream social on 10/23/24 at 2:30 pm. 2. AA B immediately separated the residents, and Resident 120 was moved away from other female residents in the activity. Resident 22 continued activity as normal. 3. The Activities Director (AD) approached Assistant Director of Nursing (ADON) the following day, 10/24/24, to notify her of the abuse. 4. ADON then called the Responsible Parties for both residents and educated [AA B] on abuse reporting. 5. AD educated all activity assistants to ensure Resident 120 is not seated next to female residents during group activities to avoid temptation on his part. A review of Alert Charting, dated 10/29/24 at 8:29 pm, indicated Resident 120 was sitting inside his room in his briefs when a female resident (unknown) passed by, reaching out her hand to touch Resident 120. Resident 120 went to guide her hand towards his briefs. The nursing note indicated both residents were caught before anything happened and female resident was quickly removed from the location. Will continue to monitor for changes. During an interview with FM 1 on 1/22/25 at 3:02 pm, FM 1 stated she was upset because the facility didn't notify the family of the abuse allegation for a day and a half after it happened. FM 1 stated the family would have come to the facility immediately to check on Resident 22. FM 1 stated she was familiar with Resident 120 because his room used to be near Resident 22's room. FM 1 stated, [Resident 120] is like that with female staff and residents; he's a big flirt but won't remember anything when questioned about it. (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	01/24/2025

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	During an interview with Admin and Social Services Assistant A (SSA A) on 1/24/25 at 8:57 am, Admin stated Resident 120 had one other incident of inappropriate touching before the abuse of 10/23/24. Admin stated the previous abuse was investigated by the State Agency. Admin stated staff have not witnessed other inappropriate behavior incidents from Resident 120 since 10/23/24. Admin stated Resident 120's behaviors are being monitored by staff during activities, and female residents are kept separated from Resident 120. Admin stated Resident 22's family was notified within hours of Admin learning of the abuse, noting it is possible AA B did not report the incident until the morning after the abuse occurred. Admin acknowledged AA B, who witnessed potential sexual abuse, should have informed a superior immediately. Admin further acknowledged the family should have been notified as soon as possible after the abuse, preferably the same day. During an interview with AD on 1/24/25 at 3:10 pm, AD stated the Activities staff have kept Resident 120 separated from female residents during Activities, and an aide walks around and makes sure Resident 120 is not inappropriate. AD stated they haven't had a problem with Resident 120 since 10/23/24. AD acknowledged AA B should have reported the abuse immediately on 10/23/24. A review of Inservice Education Summary indicated AA B attended an all-staff, one-hour Abuse Report Training on 8/28/24. The agenda included: 1. Admin is the abuse coordinator, 2. Locations of necessary paperwork and phone numbers for abuse reporting, and 3. Timeframe: a. Clock starts ticking from the time of the event. b. 2 hours from the time of the event to notify via the phone. c. 24 hours to send in SOC (SOC 341 - a form used in California to report suspected abuse of an elderly or dependent adult). A review of Acknowledgment, signed by AA B on 8/28/24, indicated AA B viewed a state-approved video titled Your Legal Duty: Reporting Elder Abuse and Dependent Elder Abuse. AA B acknowledged understanding that California state law requires mandated reports follow specific requirements for reporting known or suspected cases of abuse to the proper authorities. AA B acknowledged understanding that she must also follow the facility's internal reporting policies and procedures.

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	01/24/2025

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 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** 49418 Based on interview and record review, the facility failed to report sexual abuse to the State Agency (SA) and family in the mandated timeframes for one of four sampled residents (Resident 22). This failure delayed an investigation of the incident and created the potential for ongoing resident-to-resident sexual abuse for residents within the facility. Findings: A review of facility Policy and Procedure (P&P) titled Abuse, Neglect, Exploitation, and Misappropriation (stealing) Prevention Program, dated 8/2024, indicated residents have the right to be free from abuse - including but not limited to the freedom from verbal, mental, sexual, or physical abuse - by anyone: staff, other residents, family members, visitors, and any other individual. The P&P indicated the facility will: 1. Establish and maintain a culture of compassion and caring for all residents, particularly those with behavioral, cognitive, or emotional problems. 2. Provide staff training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, and stress management. 3. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or stolen resident property. 4. Investigate and report any allegations within timeframes required by federal requirements. 5. Protect residents from any further harm during investigations. A review of Facility-Reported Incident (FRI) Intake Information to State Agency (SA), dated 10/24/24 at 2:42 pm, indicated Resident 22 was seen with her hand in [Resident 120's] pants on top of his brief (adult diaper) on 10/23/24 at 2:30 pm. Resident 120's pants were unzipped. The abuse occurred more than 24 hours before it was reported to SA. A review of a letter from facility Administrator (Admin) to SA, dated 10/29/24, indicated: 1. AA B witnessed Resident 120 holding Resident 22's hand in his unzipped pants over his brief (adult diaper) during an ice cream social on 10/23/24. 2. AA B immediately separated the residents, and Resident 120 was moved away from other female residents in the activity. Resident 22 continued the activity as normal. 3. The Activities Director (AD) approached Assistant Director of Nursing (ADON) the following day, 10/24/24, to notify her of the abuse. (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	01/24/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. ADON then called the Responsible Parties for both residents and educated [AA B] on abuse reporting. A review of Resident 22's medical records indicated Resident 22 was admitted on [DATE] with diagnoses of dementia (a chronic condition causing decline in thinking, memory, and reasoning skills), anxiety disorder (a mental health condition characterized by excessive fear or apprehension of real or perceived threats), transient cerebral ischemic attack (TIA - a mini stroke, occurring when blood flow to the brain is briefly cut off), and major depressive disorder (a mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities). A review of Resident 22's Active Orders, dated 8/21/24, indicated Family Member 1 (FM 1) was Resident 22's surrogate decision maker because she did not have the mental capacity to understand choices, to make her own healthcare decisions, and/or participate in her treatment plan. This indicated Resident 22 did not have the mental capacity to consent to sexual contact. A review of Resident 22's Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated 12/20/24, indicated a score of 3 on a scale of 0-15 or severe cognitive impairment (a decline in mental function making it difficult to learn, remember things, and make her own decisions). This indicated Resident 22 did not have the mental capacity to consent to sexual contact. A review of Resident 120's medical records indicated Resident 120 was admitted on [DATE] with diagnoses of dementia, unspecified intracranial injury (brain damage) with loss of consciousness of unspecified duration, anxiety disorder, major depressive disorder, and affective mood disorder (a mental health condition that involves extreme mood swings and disruptions). A review of Resident 120's BIMS, dated 12/18/24, indicated a score of 9 or moderate cognitive impairment. A review of Resident 120's Care Plan, dated 1/24/25, indicated: 1a. Psychosocial - Behavior: [Resident 120] exhibits behaviors of touching other female residents in groin area or placing female resident hand on his groin area, initiated 7/3/24, revised 11/1/24. 1b. Goals: Will respond to early interventions influencing the alterability (ability to change) of behaviors, initiated 7/3/24, target date 3/18/25. Will not have any incident of this behavior through review date, initiated 7/3/24, revised 11/1/24, target date 3/18/25. 1c. Interventions: i. Activities assessment for diversional activities, administer medication as ordered, anticipate needs and meet promptly, observe and document changes in behavior including frequency of occurrence and potential triggers, initiated 7/3/24. ii. Group activities this resident will not sit next to female residents to avoid behavior (sic), initiated 11/1/24. (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	01/24/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2a. Sexual Activity: [Resident 120] exhibits [x] inappropriate sexual behavior towards female staff and female residents, attempts to touch females inappropriately, sexual comments made to female staff, initiated and revised 10/24/24. 2b. Goals: Will not act on sexually inappropriate impulses and Will not experience adverse health problems or injury related to sexual activity, initiated 10/24/24, target date 3/18/25. 2c. Interventions: Activities assessment for diversional activities, administer medication as ordered, distract and direct as needed, monitor for signs of complications related to sexual activity (infection, injury) and notify physician if observed, notify physician and responsible party as indicated, resident has been educated about safe sex practices including prophylactic measures, Social Services as indicated, and visual deterrent to aid in reduction of attempts at inappropriate sexual activity, all initiated 10/24/24. 3. Cognition: Resident 120 has impaired cognitive function/dementia or impaired thought processes related to diagnosis of dementia, revised 2/19/24, with interventions including cue, reorient and supervise as needed, initiated 2/19/24. During an interview with Family Member (FM) 1 on 1/22/25 at 3:02 pm, FM 1 stated she was upset because the facility didn't notify the family of the abuse allegation for a day and a half after it happened. FM 1 stated the family would have come to the facility immediately to check on Resident 22. During an interview with Admin and Social Services Assistant A (SSA A) on 1/24/25 at 8:57 am, Admin stated Resident 22's family was notified within hours of Admin learning of the abuse, noting it is possible AA B did not report the incident until the morning after it occurred. Admin acknowledged AA B, who witnessed the abuse, should have informed a supervisor immediately. Admin acknowledged the family should have been notified as soon as possible after the abuse, preferably the same day. During an interview with AD on 1/24/25 at 3:10 pm, AD acknowledged AA B should have reported the abuse immediately on 10/23/24. A review of Inservice Education Summary indicated AA B attended an all-staff, one-hour Abuse Report Training on 8/28/24. The agenda included: 1. Admin is the abuse coordinator, 2. Locations of necessary paperwork and phone numbers for abuse reporting, and 3. Timeframe: a. Clock starts ticking from the time of the event. b. Two hours from the time of the event to notify via the phone. c. 24 hours to send in SOC (SOC 341 - a form used in California to report suspected abuse of an elderly or dependent adult). (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	01/24/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Acknowledgment, signed by AA B on 8/28/24, indicated AA B viewed a state-approved video titled Your Legal Duty: Reporting Elder Abuse and Dependent Elder Abuse. AA B acknowledged understanding that California state law requires mandated reports follow specific requirements for reporting known or suspected cases of abuse to the proper authorities. AA B acknowledged understanding that they must also follow the facility's internal reporting policies and procedures.

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	01/24/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51253 Based on observation, interview, and record review, the facility failed to ensure accurate resident assessments for two of 29 residents (Resident 68 and 303) when: 1. Resident 68 was assessed as continent (able to control bladder which holds urine) when she was occasionally incontinent (not able to control her bladder). 2. Resident 303 was assessed as a non-smoker but was a smoker and was observed smoking. This failure had the potential for inaccurate resident care planning and adverse health outcomes for Resident 68 and Resident 303. Findings 1. A review of the facility's policy, Facility assessment dated [DATE], indicated the purpose of the assessment is to determine what resources are necessary to care for residents competently both during day to day competencies and emergencies. Genitourinary is a section included in this Assessments Policy and under this section is bladder incontinence. A review of Resident 68's Admission assessment dated [DATE], indicated Resident 68 was admitted for bilateral (right and left) osteoarthritis (bone arthritis) of the knees, morbid obesity, chronic respiratory failure, and muscle weakness. A review of Resident 68's Minimum Data Sets (MDS, resident assessment) dated 4/12/24, 7/13/24 and 10/10/24, indicated she was always continent for Section H-Bowel and Bladder. A review of Certified Nursing Assistants (CNAs) documentation for coding bladder urinary continence was conducted. Documentation for Resident 68's bladder continence was reviewed from July 2024 through December 2024. Resident 68 was marked incontinent 13 times in July, 14 times in August, 11 times in September, 6 times October, 12 times November, and 18 times in December, which did not match what was coded on her MDS reviews. During an interview on 1/21/25 at 8:48 am, Resident 68 stated she was incontinent at night and does urinate in her brief. Resident 68 explained she was able to use her bed pan during the day and evening. During an interview with Licensed Nurse (LN) Q on 1/22/25 at 8:13 am, LN Q confirmed Resident 68 had night-time incontinence when she slept. During an interview with CNA N on 1/22/25 at 10:24 am, CNA N confirmed Resident 68 was incontinent of bladder at night sometimes. CNA M stated they have cared for Resident 68 over the past year. During a concurrent interview and record review on 1/23/25 at 8:51 am, the Minimum Data Set nurse (MDS) explained if Resident 68 was incontinent at night then Section H should have been marked occasionally incontinent. (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	01/24/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/23/2025 at 11:32 am, Director of Nursing (DON) confirmed the MDS assessments were inaccurate and that Resident 68 was not continent of urine. 43755 2. A review of the facility's policy titled, Non-Smoking Policy-Residents dated January 2024, the policy indicated This facility is a non-smoking facility 1. Prior to, and upon admission, residents are informed of the facility non-smoking policy. 2. Smoking is only permitted by residents . off property. A review of Resident 303's Admission Record (undated), indicated Resident 303 was admitted on [DATE] with diagnoses that include osteomyelitis (bone infection) of right leg, diabetes, right below the knee amputation (a surgical procedure where a limb (arm or leg) is removed), muscle weakness, lack of coordination, high blood pressure and nicotine dependence. Resident 303 was his own responsible party. During an interview and observation on 1/21/25 at 8:44 am, Resident 303 was sitting in his wheelchair (w/c) in the facility hallway. Resident 303 indicated that he was a smoker and since this was a non-smoking facility, he would wheel out to the sidewalk to smoke. During an interview on 1/21/25 at 9:00 am, LN W confirmed Resident 303 was a smoker and went outside to the curb to smoke. A review of Resident 303's, Nursing-Admission/Readmission Evaluation/ Assessment (NAREA) dated 1/8/25, documented by LN V, indicated Resident 303 was a non-smoker. During an interview with LN V and record review on 1/24/25 at 11:50 am, Resident 303's NAREA, dated 1/8/25, was reviewed. LN V confirmed that Resident 303 was a smoker, but she documented on the NAREA that he was not a smoker because this was a non-smoking facility. LN V confirmed she documented this incorrectly and she should have identified Resident 303 as a smoker. During an observation on 1/24/25 at 12:09 pm, Resident 303 was observed sitting in his w/c on the sidewalk, by the street, in front of the facility and smoking a cigarette. During an interview with the Administrator (Admin) on 1/24/25 at 12:45 pm, Admin indicated that the NAREA's should reflect if a resident was a smoker, even if they have to go off facility property to smoke, so that a resident can receive appropriate treatment and care.

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	01/24/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on observation, interview, and record review, the facility failed to ensure residents received services that met professional standards of quality for two of nine residents when: 1. Resident 69's physical needs were not accommodated when Durable Medical Equipment (DME) was not provided by the Therapy Department. 2. Resident 68 did not receive needed medical referrals. This failure had the potential to result in emotional stress, anger, depression, feelings of neglect, and the potential for negative clinical outcomes. Findings: During a review of the facility's policy revised 8/2024, titled, Assistive Devices and Equipment, indicated the facility provides and maintains the use of assistive devices and equipment for residents. Devices and equipment that assist with resident mobility, safety, and independence are provided for residents. The devices include but are not limited to wheelchairs (W/Cs.) During a review of a facility policy, revised 10/2024, titled, Activities of Daily Living (ADLs), Supporting, indicated residents will be provided care, treatment, and services appropriate to enable them to carry out activities of daily living (ADL). Residents will be provided with care, treatment, and services to ensure that their ADLs are completed. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident to include hygiene, (bathing, dressing, grooming, oral care, and denture care), mobility (transfer and ambulation, including walking), elimination (toileting), and dining (melas and snacks). The residents' response to interventions will be monitored, evaluated, and revised appropriately. During a review of the facility's policy, revised 10/2023, titled, Resident Rights, indicated employees shall treat all residents with kindness, respect and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to a dignified existence, self-determination, and to exercise his or her rights as a resident of the facility. This facility's policy also indicated the resident will be supported by the facility in exercising rights, and will be informed of, and participate in his or her care planning and treatment. During a review of Resident 69's medical record the, Admission Record, indicated Resident 69 was admitted to the facility on [DATE] with diagnoses that included right side hemiplegia (paralysis, unable to use or move the right side of body) following a Cerebral Vascular Accident (CVA, commonly called stroke), dysphagia (difficulty swallowing), acquired absence of left leg (below the knee amputation), heart disease, and major depressive disorder (a mental condition that can cause persistent feelings of sadness and loss of interest in activities). (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	01/24/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) dated 11/29/24, indicated that Resident 69 had a Brief Interview for Mental Status, (BIMS) score of 13 out of 15 and was cognitively intact (able to think and reason). This MDS also indicated Resident 69 required substantial/maximum assistance with all transfers out of bed. During an interview on 1/21/25 at 9:27 am, Resident 69 stated, I want my wheelchair they measured me for back in September, I cannot even get out of bed without being uncomfortable. My insurance bought me a new chair and they lost it. My goal was get my new wheelchair and push myself around here. During an interview on 1/22/25 at 8:46 am, Certified Nursing Assistant (CNA) D stated, Resident 69 refuses to get out of bed because he says his wheelchair is not comfortable, so he does stay in the bed unless he gets a shower. During an interview on 1/22/25 at 10:20 am, the Rehabilitation Therapy Director (RTD) stated, I misspoke, the company never delivered [Resident 69's] wheelchair, I thought it was delivered in September. I confirm I did not follow up with Resident 69 or the DME company for the delivery. The RTD confirmed Resident 69 needed a specific W/C and his needs were not met. During an interview on 1/22/25 at 2:50 pm, the Administrator confirmed Resident 69 did not receive the W/C he was measured for, and there was no was no follow up by any therapy or nursing staff to make sure the W/C was delivered. 51253 2. A review of Resident 68's Admission assessment dated [DATE], indicated Resident 68 was admitted for bilateral (right and left) osteoarthritis (bone arthritis) of knee, morbid obesity, chronic respiratory failure, and muscle weakness. During an interview on 1/21/25 at 8:48 am, Resident 68 stated she requested to see the Medical Director and has not seen him. Resident 68 stated her right knee was painful and it made clicking noises when she moved it. Resident 68 was also wanting to address an IUD [Intrauterine Device that is inserted into the uterus], that needs removed. She voiced concerns about getting a physical to check her out and stated no one ever listens to her. During a concurrent interview and record review on 1/23/2025 at 11:32 am, Director of Nursing (DON) confirmed Resident 68's physician gave gynecology [female doctor] referrals three times for Resident 68, on 8/21/24, 1/13/25 and again on 1/15/25, and the appointments were never made. DON confirmed the licensed nurses were responsible for arranging the appointments and this did not happen. DON confirmed there were no referrals obtained for Resident 68's right knee pain.

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	01/24/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on observation, interview, and record review, the facility failed to provide the necessary assistance for Activities of Daily Living (ADLs, activities related to personal care) for dependent residents for two of six sampled residents, (Resident 68 and Resident 69) when: 1. Resident 69 did not get out of bed (OOB) due to not having an appropriate wheelchair (W/C) to meet his specific needs; and 2. Resident 69 did not receive scheduled showers, or as needed showers for January 2025; and 3. Resident 68 did not receive assistance for toileting using a bed pan (device to collect urine while lying or sitting in bed) upon request. These failures had the potential to result in emotional stress, anger, depression, feelings of neglect, denial of resident rights, and prevent the residents from achieving their highest practicable level of physical and emotional well-being. Findings: 1. During a review of a facility policy revised 10/2024, titled, Activities of Daily Living (ADLs), Supporting, indicated residents will be provided care, treatment, and services appropriate to enable them to carry out activities of daily living (ADL). Residents will be provided with care, treatment, and services to ensure that their ADLs are completed. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident to include hygiene, (bathing, dressing, grooming, oral care, and denture care), mobility (transfer and ambulation, including walking), elimination (toileting), and dining (meals and snacks). The resident's response to interventions will be monitored, evaluated, and revised appropriately. During a review of the facility's policy, revised 10/2023, titled, Resident Rights, indicated employees shall treat all residents with kindness, respect and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to a dignified existence, self-determination, and to exercise his or her rights as a resident of the facility. This facility's policy also indicated the resident will be supported by the facility in exercising rights, and will be informed of, and participate in his or her care planning and treatment. During a review of Resident 69's medical record, the Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included right side hemiplegia (paralysis, unable to use or move the right side of body) following a Cerebral Vascular Accident (stroke), dysphagia (difficulty swallowing), acquired absence of left leg (below the knee amputation), heart disease, and major depressive disorder (a mental condition that can cause persistent feelings of sadness and loss of interest in activities). (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	01/24/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) dated 11/29/24, indicated that Resident 69 had a Brief Interview for Mental Status, (BIMS) score of 13 out of 15 and was cognitively intact (able to think and reason). This MDS also indicated Resident 69 required substantial/maximum assistance with all transfers OOB. During an interview on 1/21/25 at 9:27 am, Resident 69 stated, I want my wheelchair they measured me for back in September, I cannot even get out of bed without being uncomfortable. My insurance bought me a new chair and they lost it. My goal was get to my new wheelchair and push myself around here. During an interview on 1/22/25 at 8:46 am, Certified Nursing Assistant (CNA) D stated, Resident 69 refuses to get out of bed because he says his wheelchair is not comfortable, so he does stay in the bed unless he gets a shower. During an interview on 1/22/25 at 2:50 pm, the Administrator confirmed Resident 69 did not receive the W/C he was measured for, and there was no follow up by any therapy or nursing staff to make sure the W/C was delivered. During an interview on 1/22/25 at 3:00 pm, the Administrator confirmed Resident 69 had not been OOB except for showers since September 2024, and she had not been updated until inquiring about his W/C that was ordered. Admin stated, I will make sure [Resident 69] has a wheelchair to use that is comfortable so he can get out of bed until the new one ordered is delivered. 2. During a review of Resident 69's medical record, a document dated January 2025, titled, Documentation Survey Report v2, indicated Resident 69 received one scheduled shower on 1/2/25, one refusal was documented on 1/11/25 which indicated five showers were not offered or provided as scheduled, twice a week, for January 2025. During a review of a facility document dated January 2025, not titled but listed the shower schedules. Resident 69 was scheduled for showers on every Monday and Thursday morning. During an interview on 1/22/25 at 3:10 pm, the Director of Nursing (DON) confirmed Resident 69 did not get all scheduled showers for January 2025. DON stated, My expectation is every resident gets their showers as scheduled two times weekly and per request, unless they refuse. We just changed the schedule for evening showers instead of mornings per resident request for [Resident 69]. 51253 3. A review of Resident 68's Admission Assessment, dated 12/14/23, indicated Resident 68 was admitted for bilateral osteoarthritis of knee, morbid obesity, chronic respiratory failure, and muscle weakness. A review of Resident 68's MDS dated [DATE], indicated under the section functional abilities that the activity of toilet transfer (ability to get on and off toilet) and walking was not attempted by Resident 68. (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	01/24/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Check and Change care plan dated 1/8/25, indicated Resident 68 uses a bed pan by herself and staff assist her off the bed pan and change her incontinence brief if needed. The goals were to have decreased incontinence and she will maintain comfort and dignity. During an interview with Resident 68 on 1/21/25 at 8:48 am, Resident 68 stated some staff do not help her. Resident 68 stated that she has bouts of incontinence in the night and she wakes up wet and cold. Resident 68 explained she uses the bed pan independently and sometimes the urine spills out on to the sheet and on the blanket. Resident 68 has requested for help, and Licensed Nurse (LN) Q and some of the other staff tell her to do it yourself. Resident 68 stated she was unable to get up on her own to help herself to the bathroom and required staff assistance. Resident 68 stated she feels cold and uncomfortable. During an interview of CNA M on 1/21/25 at 3:45 pm, CNA M stated Resident 68 can get up and go to the bathroom whenever she wants by herself. CNA M stated that Resident 68 was perfectly capable of cleaning herself. CNA M stated she did not need to get Resident 68 out of bed because she can get up on her walker and do it herself. During an interview of LN Q on 1/22/25 at 8:13 am, LN Q stated Resident 68 had night-time incontinence when she slept. LN Q stated Resident 68 was fully capable of cleaning herself. LN Q stated she does not need to help Resident 68 after soiling herself in bed. During an interview of CNA N on 1/22/25 at 10:24 am, CNA N stated Resident 68 was incontinent of bladder at night sometimes. CNA N stated Resident 68 was dependent for mobility with a one person assist with walker although she has to be followed with wheelchair because she get weak. During an interview on 1/24/25 at 11:32 am, DON was informed of the observed interaction between CNA O and Resident 68 who requested a biscuit for breakfast on 1/22/25. DON confirmed direct staff should treat all residents who requested assistance dignified and honored. DON stated it was disrespectful to argue loudly with Resident 68. DON confirmed Resident 68 should receive help when she asks for it regardless of her abilities. During an interview on 1/24/25 at 12:02 pm, Director of Staff Development (DSD) confirmed that Resident 68 was dependent on staff for activities of daily living. DSD confirmed that telling Resident 68 to do it yourself when she requested help with ADLs, was a lack of accommodation and not acceptable.

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	01/24/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49418 Based on observation, interview, and record review, the facility failed to provide 1 of 29 sampled residents (Resident 44) with quality of care that met their needs when Resident 44 did not receive adequate foot care (washing, applying lotion, and assessing the skin). This failure resulted in discomfort and dry, cracked, and peeling feet for Resident 44. A review of the facility's Policy and Procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting, dated 10/2024, indicated: 1. Residents will be provided care, treatment, and services as appropriate to enable them to carry out ADLs, for example, bathing, dressing, oral hygiene, walking, transferring in bed, toileting, and eating. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with resident consent and in accordance with the plan of care, including appropriate support and assistance. 3. A resident's ability to perform ADLs will be measured using clinical tools. 4. The resident's responses to interventions will be monitored, evaluated, and revised as appropriate. A review of Resident 44's medical records indicated she was admitted [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD, constriction of the airways making it difficult or uncomfortable to breathe), morbid (severe) obesity, muscle weakness, reduced mobility (ability to walk, transfer in bed), chronic pain, atrial flutter (irregular heart rhythm), and chronic kidney disease (CKD, a long-term condition that occurs when the kidneys are damaged and cannot filter blood properly, which can lead to a buildup of waste and excess fluid in the body. Symptoms may include itchy or dry skin and swelling in the hands, feet, or ankles). A review of Resident 44's Care Plan revised 2/13/24, indicated the following: 1. Resident 44 is at risk for skin breakdown due to abnormal labs, COPD, edema (swelling caused by a buildup of fluid in the body's tissues), impaired ability to perform Activities of Daily Living (ADLs, bathing, dressing, oral hygiene, toileting, and eating), impaired mobility (walking, transferring in bed), kidney disease, obesity, pain, and age. Goals included preventing or delaying skin breakdown to the extent possible given risk factors (revised 2/27/24, target date 2/10/25). Interventions included, Check skin during daily care provisions. Notify physician of abnormal findings, (initiated 2/9/24), and Lotion skin daily with ADL care unless contraindicated (not advised), (initiated 2/9/24). (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	01/24/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 44's Skin Impairment care plan indicated Resident 44 has skin impairment and is at risk for delayed healing and infection related to two open areas to left upper breast (revised 10/8/24). Goals included compliance with treatments and intervention measures to prevent skin breakdown (initiated 10/8/24, target date 2/10/25), will have adequate circulation to lower extremities as evidenced by no development of new ulcers (initiated 10/8/24, target date 2/10/25), and will have optimal skin integrity as allowed by clinical status (initiated 10/8/24, target date 2/10/25). Interventions included assess skin turgor (elasticity), (initiated 10/8/24), and check skin during daily care provisions (initiated 10/8/24). A review of Note Text, Alert Charting, dated 5/23/24 at 11:55 pm, indicated Resident 44 made negative statements about staff not taking her socks off earlier. The note indicated Resident 44's socks were taken off and lotion was applied to bilateral feet as the skin was noted to be very dry. A review of Nursing Weekly Summary, dated 5/25/24, for Resident 44 indicated, No new skin issues this week and Skin clear and intact. A review of Nursing Weekly Summary, dated 10/13/24, indicated Resident 44 had two small wounds to the left breast, two abrasions on the left forearm, and No new skin issues this week. A review of Nursing - Weekly Summary, dated 10/19/24, indicated Resident 44 had No new skin issues this week and Skin clear and intact. A review of Nursing Weekly Summary, dated 10/26/24, 11/2/24, 11/9/24, 11/23/24, 12/14/24, 1/4/25 indicated Resident 44 had, No new skin issues this week. , A review of Nursing Weekly Summary, dated 11/16/24, 12/7/24, 12/28/24, indicated unchecked boxes for Resident 44's skin assessment with na or n/a (not applicable) typed in the Comment section. A review of Nursing Weekly Summary, dated 11/30/24, 12/21/24, and 1/11/25, indicated Resident 44 had No new skin issues this week and Skin clear and intact. A review of Nursing Weekly Summary, dated 1/18/25, indicated, Two small open areas on left breast noted upon exam. Hx (history) of scratching area with right hand and back scratcher. Medical Doctor (MD) notified new treatment order obtained. During a concurrent observation and interview with Resident 44 in the resident's room on 1/23/25 at 10:56 am, observed Resident 44 lying in bed with feet outside of the blanket. Observed the bottoms of Resident 44's feet to be dry, cracked, and peeling yellowish white tissue from tips of toes to heels. The foot of the bed was noted to have multiple skin flakes on blankets and mattress. When asked if staff provided foot care, Resident 44 stated she likes to have Aquaphor cream put on her feet and legs, but it doesn't happen very often. Resident 44 stated sometimes a family member will apply the cream when they visit. (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	01/24/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Licensed Nurse (LN) S on 1/24/25 at 8:26 am, LN S stated if they saw a resident with really dry feet, they would call the doctor. During a concurrent observation of Resident 44's feet and interview with Certified Nurse Assistant (CNA) D on 1/24/25 at 8:35 am, CNA D stated Resident 44's feet were very dry and scaly. CNA D stated if she found a resident's feet this way, she would put lotion on the feet and cover them with socks, inform the resident's nurse, and request vitamin E cream. During an interview with Director of Staff Development (DSD) and Consultant (CONS) on 1/24/25 at 11 am, DSD stated the expectation for CNAs who found a resident with dry scaly feet would be to clean the feet and report the skin breakdown to the nurse. DSD stated that if the condition was chronic, she would expect the resident would receive long-term treatment, that it would be care-planned, and if Resident 44 refused treatments, that should be documented by staff.

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	01/24/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 123), was turned and repositioned as ordered to prevent skin break down, promote circulation, and provide pressure relief. This failure resulted in areas of redness to Resident 123's skin and wrinkles to her skin from the bed linens and the potential to contribute to Resident 123 developing a pressure ulcer (open area of the skin, or bedsore caused by prolonged pressure) which could lead to complications including pain, discomfort, and infection. Findings: During a review of the facility's policy revised 5/2013, titled, Repositioning, indicated the purpose of repositioning is to provide guidelines for the evaluation of resident's repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. Repositioning is a common, effective intervention for preventing skin break down, promoting circulation, and providing pressure relief. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. During a review of the facility's policy revised 4/2020, titled, Prevention of Pressure Injuries, indicated the purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. Identify any signs of developing pressure injuries (non-blanchable erythema), inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.) and reposition resident as indicated on the care plan. Reposition all residents with or at risk of pressure injuries on an individualized schedule and choose a frequency for repositioning based on the resident's risk factors, and current clinical practice guidelines. During a review of a policy revised 3/2018, titled, Activities of Daily Living (ADLs), Supporting, indicated residents who are unable to carry out ADLs [Activities of Daily Living] independently will receive appropriate care and services for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene, (bathing, dressing, grooming, and oral care), mobility (transfer and ambulation, including walking), elimination (toileting), and dining (meals and snacks). The resident's response to interventions will be monitored, evaluated, and revised appropriately. During a review of Resident 123's medical record, the Admission Record, indicated Resident 123 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia (decline in mental ability such as thinking, remembering, and reasoning that affect activities of daily life), diabetes (too much sugar in the blood), dysphagia (difficulty swallowing), Lichen Sclerosis ET Atrophicus (long lasting skin disorder that often affects the genitals and anus which causes inflammation and itching), depressive disorder (persistent feelings of sadness and loss of interest in activities), and seizures (sudden, uncontrollable body movements that occur due to abnormal electrical activity in the brain). (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	01/24/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) dated 1/30/25, indicated that Resident 123 had a Brief Interview for Mental Status, (BIMS) score of 00 out of 15 which indicated Resident 123 was not able to complete the interview and had a severe cognitive deficit (ability to think and reason). This MDS also indicated Resident 123 was totally dependent on staff for all activities of daily living (ADLs, personal care tasks, dressing, toileting, bathing, hygiene, transfers, eating, and turning in bed). During a review of Resident 123's medical record, a record revised 5/2/24, titled, Care Plan, indicated Resident 123 was at risk for skin breakdown related to dementia, and impaired ADL ability. One of the interventions listed for Resident 123 on this care plan indicated the staff were to turn and reposition as indicated/tolerated. During a review of Resident 123's medical record, a record dated March 19, 2025, titled, Order Summary Report, indicated to turn and reposition Resident 123 every two hours and document if she refused. During an interview on 3/18/25 at 12:10 pm, a Family Member (FM) 1 stated, I don't think they turn [Resident 123], she is always lying on her back every time I come to visit. During an observation on 3/19/25 at 8:55 am, Resident 123 was lying in bed, a white towel was covering the pillow for resident's head. Resident 123 was observed wearing a hospital gown, eyes closed, no signs or symptoms of pain or discomfort. During an interview on 3/19/25 at 9:05 am, Licensed Nurse (LN) F stated, Yes, they turn resident [123], the Certified Nursing Assistants (CNAs) turn her every two hours. During an interview on 3/19/25 at 9:30 am, FM 2 stated, They never turn [Resident 123], her husband comes in every day. The staff doesn't even go over there. During an interview on 3/19/25 at 9:40 am, CNA C stated, Night shift staff turns [Resident 123] at 6:00 am, then 8:30 am the staff should turn her again after her breakfast. We keep [Resident 123] on her back for meals, she has to be fed, but she should be on her side now. During an interview on 3/19/25 at 10:16 am, the Director of Nursing (DON) stated, There is a physician's order for [Resident 123] to be turned and repositioned every 2 hours. It is on the Electronic Medical Record (EMAR) for the nurses to fill in. During a concurrent observation and interview on 3/19/25 at 11:35 am, CNA C confirmed Resident 123 had not been turned or repositioned since 9:40 am, and Resident 123 was still lying on her back. CNA stated, I think the towel under her head is from a shower today. I think her CNA is at lunch, I will go get someone to help me. During an observation on 3/19/25 at 11:55 am, CNA A and CNA C changed a soiled brief (incontinent pad) and turned resident on her left side to provide hygiene care and to change the incontient brief. Resident 123 was observed to have multiple red areas to her upper thighs and both buttocks. Resident 123 was observed with visible indentations and red lines on the backs of her upper legs, buttocks, and lower back area from lying on her wrinkled, folded, white sheet in bed. (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	01/24/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/25 at 12:30 pm, FM 3 stated, This is my second home, I am so glad to see [Resident 123] out of bed, it has been a while since I have seen her up. During an interview on 3/19/25 at 12:45 pm, CNA D confirmed she had not turned or positioned Resident 123 on her side since her shift started in the morning. CNA D stated, No, I have not turned or positioned [Resident 123] on her side today, I just moved the pillow under her legs. [Resident 123] has not had a shower, the towel is on her pillow because Resident 123 will sweat at times. During an interview on 3/19/25 at 12:50 pm, CNA A confirmed Resident 123 had not been turned or repositioned on day shift, stated, I confirm the lines on her bottom and legs were from the sheet she was lying on. During an interview on 3/19/25 at 12:54 pm, the DON confirmed Resident 123 had not been turned and positioned every two hours as ordered. DON stated, I confirm turning and positioning is important to prevent skin break down and prevent pressure wounds, and I will begin training immediately. During an interview on 3/19/25 at 1:30 pm, the Administrator (Admin) confirmed Resident 123 needed to be turned and repositioned to prevent any skin problems. Admin stated, I confirm education is needed and we will implement a new process immediately.

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	01/24/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32797 Based on observation, interview, and record review, the facility failed to ensure resident's plan of care met their needs and provided supervision required to keep them free from accidents and hazards for two of five sampled residents (Resident 250 and 303) when: 1. Resident 250 was known to the facility to have restless/aggressive behaviors, active infection and had been evaluated to be at a high risk for falls. The facility failed to re-evaluate past interventions, identify the root cause of Resident 250's falls and develop resident specific individualized interventions to prevent accidents. This resulted in repeated falls for Resident 250 and subsequently, a bilateral head injury that required a 12-day hospitalization . 2. Resident 303 a) Was not identified as a smoker on admission but was seen smoking on the sidewalk. b) Smoked off campus without facility knowledge. c) Kept his cigarettes and lighters in his room unsecured. d) Was not evaluated for smoking safety on admission but 14 days later was evaluated to need a smoking apron and did not wear one while smoking. e) The path provided for Resident 303 to go off the facility property to smoke, had a large pothole along the path. The facility's lack of safety interventions for Resident 303 had the potential for injury related to smoking. Findings: A review of facility's policy titled, Assessing Falls and Their causes, revised August 2024, indicated the purpose of the policy is to provide guidelines for investigation and assessing a resident after a fall and to assist staff in identifying causes of the fall. Review the resident's care plan to assess for any special needs of the resident. The policy indicated residents must be assessed in a timely manner for potential causes of falls and relevant environmental issues should be addressed promptly. Investigation of a Fall or Fall Risk included time of day, time of last meal, what the resident was doing, was resident going to toilet, and whether there is a pattern of falls for this resident. Nursing staff will collect and evaluate information until they either identify the cause or determine cause cannot be found. (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	01/24/2025

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	A review of Resident 250's Admission record indicated Resident 250 was admitted on [DATE], with diagnoses of urinary tract infection requiring intravenous (IV, way to deliver fluids, medicine, or blood directly into a vein) antibiotics (treats infection) treatment, dementia, muscle weakness, difficulty walking, and unsteadiness on feet. A review of Resident 250's Nursing Admission Evaluation Assessment date 10/7/24 at 3:53 pm, indicated under orientation the acute hospital report indicated Resident 250 had confusion and episodes of agitation. Resident 250 was admitted to the skilled nursing facility with a urinary catheter (a tube that drains urine from bladder) and a midline central IV to right upper arm, placed on 10/6/24. A review of Resident 250's Baseline Care Plan dated 10/7/24, indicated Resident 250 was alert and oriented to self with increased confusion at night. Care plan indicated Resident 250 was a high fall risk due to dementia, being confused and had a urinary tract infection which can cause increased confusion. A review of a Minimum Data Set (MDS, resident assessment) dated 10/10/24, indicated Resident 250 had a Brief Interview for Mental Status (BIMS, resident memory and decision making abilities) score was of 4 out of 15, indicating a severe impairment. Resident 250 was an extensive (dependent on one to two staff to help him) assist for all activities of daily living and transfers. A review of a Nursing Fall Risk assessment dated [DATE], 10/10/24, and 10/12/24 indicated Resident 250 was a high risk for falls. A review of an Alert Charting Progress note dated 10/7/24 at 6:24 pm, shortly after admission, indicated Resident 250 was agitated not getting along with his roommate. Resident 250 had thrown a cup of water onto his bed and was moved to another room in the facility. A review of an Alert Charting Progress note dated 10/7/24 at 11:55 pm, indicated Resident 250 had a new roommate and he was not get along with him either. Resident 250 was very confused and pulling/dragging on his urinary catheter. A message was left for the Medical Director (MD), requesting a medication for anxiety. A review of an Alert Charting Progress note dated 10/8/24 at 6:17 pm, indicated Resident 250 frequently gets up and walks around without calling for assistance. Resident 250 had removed all of his clothing and pulled at the urinary catheter multiple times. A review of a Fall Care Plan dated 10/8/24, indicated a goal that Resident 250 would not experience a fall related to risk factors. Interventions included; Keep call light in reach, anticipate needs, keep personal items within reach, monitor for changes in condition and notify physician, proper footwear non-skid socks, and safety devices. Fall #1: A review of an Alert Charting Progress note dated 10/8/24 at 8:30 pm, indicated Resident 250 had an unwitnessed fall with no injuries. He was found sitting on the floor next to his bed. Resident 250 was very confused, restless, and agitated. MD was notified and new orders were given for Ativan (anxiety medication produces a calming effect on the brain and nerves), for restlessness. Documentation reflected that Resident 250 wandered and could not stay in bed. (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	01/24/2025

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	A review of an online resource from National Library of Medicine, Daily Med, indicated in a sample of about 3500 patients treated for anxiety, the most frequent adverse reaction to Ativan (lorazepam) was sedation (15. 9%), followed by dizziness (6.9%), weakness (4.2%), and unsteadiness (3.4%). The incidence of sedation and unsteadiness increased with age. Paradoxical (opposite) reactions, including anxiety, excitation, agitation, hostility, aggression, rage, sleep disturbances/insomnia, sexual arousal, and hallucinations may occur. A review of a Infection Control Interdisciplinary Team (IDT, where facility managers meet to discuss plans of care for residents) note dated 10/8/24 at 2:35 pm, indicated Resident 250 had a change of condition related to increased confusion and other symptoms or signs of delirium (a temporary condition with an inability to pay attention and thoughts are disorganized). A licensed nurse got an order for Ativan 0.5 milligrams (mg, a unit of measure) every 6 hours, for restlessness. According to the IDT note, the Ativan was of little help and documented, He needs stronger meds and a sitter (1:1, a caregiver sits with resident and available to assist). The IDT note indicated that Resident 250 was currently on antibiotics for an infection and, maybe he will get better once infection gone. A review of an IDT note dated 10/9/24 at 10:19 am, indicated Resident 250 had an unwitnessed fall on 10/8/24 at 8:30 pm. Certified Nurse Assistant (CNA) notified the nurse that Resident 250 was sitting on the floor next to his bed. The note indicated that Resident 250 had poor safety awareness, was impulsive, and unable to be redirected when provided with education with his urinary catheter. Resident 250 continued to wander the facility and running over his urinary catheter bag (the bag that collects the urine) and dragging it across the floor. New interventions following this fall were for Resident 250 to use a leg bag a device that attaches to the upper thigh and does not get in the way of walking, and Ativan for his restlessness. A review of a Resident 250's physician order dated 10/8/24 at 11:30 pm, indicated Ativan 0.5 mg tablet every 6 hours was ordered as needed for restlessness. Another physician ordered on the same day, to monitor the antianxiety medication for adverse side effects such as; drowsiness, slurred speech, dizziness, nausea, and aggressive impulsive behavior. A review of Resident 250's Medication Administration Record (MAR) dated October 2024, indicated Ativan 0. 5 mg had been administered five times for restlessness, on 10/8/24 at 11:45 pm, 10/10/24 at 12:35 am, 10/11/24 at 8:35 am and again at 8:47pm, and on 10/12/24 at 5:23 am. A review of an Alert Charting Progress note dated 10/9/24 at 2:48 pm, indicated Resident 250 continued not to use his call light or ask for staff assistance and continued to pull at his urinary catheter. The note indicated Resident 250 walked with an assistive device and the help of staff. A review of an Alert Charting Progress note dated 10/10/24 at 4:44 am, indicated Resident 250 continued to get up and walk by himself and refused t use call light despite unsteady balance. Fall #2: A review of an Alert Charting Progress note dated 10/10/24 at 9:30 pm, indicated Resident 250 refused to wear non-skid socks, was confused and frustrated with his urinary catheter. He had a laceration (cut) to the back of his head. The progress note indicated that staff were unable to check his pupils (to check neurological [brain] function), and Resident 250 was transferred out to the acute care hospital for evaluation. (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	01/24/2025

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	A review of an IDT note dated 10/11/24 at 10:17 am, indicated Resident 250 had an unwitnessed fall on 10/10/24 at approximately 6:33 pm. Resident 250 was found lying on his back on the floor. His wheelchair was found next to him with wheelchair unlocked. A laceration (a cut or tear in the skin caused by an injury) was found to the back of his head and staff were unable to see his pupils due to resident rolling his eyes upward. Resident 250 was sent to the emergency department for a post fall evaluation. At the hospital a Computed Tomography (CT scan, an X-ray to create detailed pictures of the inside of the body) scan was completed with no remarkable findings and he was sent back to the facility. The IDT recommended that therapy to evaluate for proper wheelchair. The IDT note did not address or evaluate the effectiveness of the administration of Ativan in reducing Resident 250's restlessness and impulsive/wandering behaviors. A review of an Alert Charting Progress note dated 10/11/24 at 4:31 pm, indicated Resident 250 was confused at his baseline, had no safety awareness, and that staff continued to redirect him to sit in a chair which made him agitated, and he continued to self-transfer and not ask for assistance. A review of an Alert Charting Progress note dated 10/12/24 at 2:46 am, indicated Resident 250 was observed walking down hallway with unsteady balance and continued to have no safety awareness. Fall #3: A review of a SBAR (Situation, Background, Assessment and Recommendation) note dated 10/12/24 at 9:27 am, indicated Resident 250 was in his wheelchair by the nursing medication cart. He tried to stand to get a spoon from the cart and fell hitting the right side of his head on the bottom of the cart. Resident 250 sustained a skin tear to his right forearm. Neurological (checks brain function) checks were started but staff were unable to complete the assessment because his eyes were rolling upward when trying to check. There was no IDT post fall note for Fall #3, it was included in the Fall #4 IDT note dated 10/14/24, two days later. There was no documented evaluation of the effectiveness of the past fall prevention interventions and no changes were made to his fall care plan. Fall #4: A review of a Nursing Progress Note dated 10/12/24 at 1:37 pm, indicated a second fall had occurred after fall #3, on the same day, but had not included the time of the fall. The note indicated that Resident 250 tried to pull out his IV and fell and hit his head on the floor. LN documented Resident 250 was assessed to be confused, drowsy, and was unable to stay awake, and he was transferred out to the acute care hospital for evaluation. A review of an IDT note dated 10/14/24 at 2:58 pm, indicated Resident 250 has suffered from four falls during a stay of seven days in the facility. The final, 4th fall, at approximately 9:45 am, Resident 250 was assisted to bed so the Registered Nurse (RN) could administer his antibiotic medication in his IV. Resident 250 was witnessed trying to remove the IV while the antibiotics were being administered. An LN tried to redirect him and left the room, once he had calmed down. Then at approximately 10:05 am, Resident 250 was found on the ground near his bed. The note indicated that Resident 250 had increased confusion and difficulty staying awake. Resident 250 was sent to the hospital emergency room and was found to have a subdural hematoma (where the blood pools in the brain from hitting the head strong enough to burst the blood vessels). (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	01/24/2025

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	A review of an online resource NationalInstituteofHealth.gov dated 8/1/24, indicated confusion will last in the elderly with a urinary tract infections as follows: Mild UTIs: Confusion often improves within 24 to 48 hours, with full recovery in 3 to 5 days. Severe or Complicated UTIs: Symptoms may last 1 to 3 weeks, especially if the infection involves the kidneys or catheters. During a concurrent interview and record review on 1/23/25 2:54 pm, Licensed Nurse (LN) AH stated she remembered Resident 250 to be very confused and needed to be monitored closely by staff for safety. LN AH stated he would sit in hallway so staff could provide close supervision, but still fell near medication cart and hit his head. LN AH stated the last fall (Fall #4), she found Resident 250 later in his room lying on the floor on the fall mat next to his bed tangled in his IV tubing. LN AH stated Resident 250 should have not been left alone especially when having antibiotics administered. LN AH stated the Ativan did not really help Resident 250, He may have needed a different medication for his restlessness and aggression. During an interview on 1/24/25 at 9:04 am, CNA Q stated she remembered Resident 250, after seeing a picture of him. CNA Q stated he was confused, agitated, and did get aggressive at times. CNA Q indicated that Resident 250 would have benefited from 1:1 supervision (caregiver always has eyes on resident and available to assist resident) due to safety concerns, but also indicated that the facility was not always able to provide 1:1 supervision due to not having enough staff to provide this. During a concurrent interview and record review on 1/24/25 at 12:30 pm, with Director of Nursing (DON) and Assistant Director of Nursing (ADON), they both confirmed Resident 250 had behaviors and falls. ADON stated she participated in the IDT meetings and was unaware that Resident 250 had a total of four falls. DON and ADON confirmed direct care staff such as CNAs and LNs were not included in the fall IDT meetings and contribute to identifying root causes of of Resident 250's confusion and multiple falls. DON and ADON confirmed that redirection, the reminder to use call light, with a BIMS of 4, and reminders to use wheelchair brakes when Resident 250 transferred himself, were not effective interventions to prevent further falls. DON and ADON indicated that Resident 250 was impulsive, restless, and had dementia (memory problems), which contributed to his poor safety awareness and inability to follow directions. DON and ADON confirmed that 1:1 supervision had not been considered until after Fall #4. DON and ADON confirmed the IDT meeting documentation had not included a review or discussion of Resident 250's behaviors if the Ativan use had been beneficial. ADON confirmed Ativan could also have the opposite desired affect and cause aggressive impulsive behaviors. DON and ADON confirmed the IDT meetings did not evaluate the risks of leaving Resident 250 alone while IV antibiotics were infusing. DON and ADON agreed that Resident 250's UTI could have contributed to his restlessness and confusion, thereby placing him at a higher risk for falls with injuries. A review of the acute care hospital discharge summary record dated 10/24/24, indicated Resident 250 was admitted to the hospital for treatment of right and left subdural hematomas. Resident 250 required treatment for respiratory failure that required intubation (a medical procedure that involves inserting a tube into the windpipe when someone cannot breathe on their own), and a feeding tube (a tube surgically placed into the stomach when food cannot be taken by mouth), because of the severity of his head injuries. Resident 250 spent 12 days in the hospital. 43755 (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	01/24/2025

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	2. a) A review of the facility's policy titled, Non-Smoking Policy-Residents dated January 2024, the policy indicated, This facility is a non-smoking facility but has grandfathered (a resident who was allowed to smoke before the new policy was put into practice was still allowed to smoke on the facility property under the new policy). 1. Prior to, and upon admission, residents are informed of the facility non-smoking policy. 2. Smoking is only permitted by residents (other than the one individual grandfathered into prior smoking policy) off property. On 1/21/25 at 8:08 am, during the entrance conference, the Administrator (Admin) indicated that the facility was a non-smoking facility except for one resident (Resident 17) that was grandfathered and allowed to smoke in designated smoking areas on the facility property. Admin indicated that anyone admitted , after smoking on the property ended in January 2024, had to sign themselves out of the facility and smoke off the facility property. The Admin indicated she did not know who smoked off the property and that there was no list of residents who smoked off the property. A review of Resident 303's Admission Record (undated), indicated Resident 303 was admitted on [DATE] with diagnoses that include osteomyelitis (bone infection) of right leg, diabetes (high sugar in the blood), right below the knee amputation (a surgical procedure where a limb (arm or leg) is removed), muscle weakness, lack of coordination, high blood pressure and nicotine dependence. Resident 303 was his own responsible party. A review of Resident 303's Admission Minimum Data Set (MDS, a clinical assessment tool), dated 1/11/25, indicated a Brief Interview of Mental Status (BIMS, an evaluation of cognition: thinking and reasoning) was conducted and Resident 303 scored a 15 out of 15 indicating he had an intact cognition. Section GG of the MDS indicated Resident 303 used a wheelchair (w/c) for locomotion and required set up and clean up assistance from staff for locomotion. During an interview and observation on 1/21/25 at 8:44 am, Resident 303 was sitting in his wheelchair (w/c) in the facility hallway. Resident 303 indicated that he was a smoker and since this was a non-smoking facility, he was supposed to sign himself out of the facility and wheel out to the curb to smoke. A review of Resident 303's Nursing-Admission/Readmission Evaluation/Assessment (NAREA) dated 1/8/25, indicated Licensed Nurse (LN) V documented Resident 303 as a non-smoker. A review of Resident 303's Comprehensive Care Plans identified that there was no documented smoking care plan. A review of Resident 303's medical record identified that Resident 303 had no documented Admission Smoking Evaluation (an evaluation that identified if a resident was safe with smoking and/or required equipment needed to be safe to smoke). During an interview on 1/21/25 at 9:00 am, LN W indicated Resident 303 was a smoker and went outside to the curb to smoke. (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	01/24/2025

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	During a concurrent interview with LN V and record review on 1/24/25 at 11:50 am, Resident 303's NAREA was reviewed. LN V indicated that Resident 303 was a smoker, but she documented on the assessment that he was not a smoker because she thought since this was a non-smoking facility, she should identify residents as non-smokers. After reviewing the medical record LN V indicated she marked it wrong, and she should have indicated that Resident 303 was a smoker. During an interview with the Administrator (Admin) on 1/24/25 at 12:45 pm, Admin indicated that Resident 303 should have been identified as a smoker so the facility could provide the appropriate safety and care needed. 2. b) During an observation and interview on 1/24/25 at 12:02 pm, Resident 303 was observed sitting in his w/c outside the facility on the facility property and listening to music. Resident 303 indicated that he liked to come outside to listen to music and that he would go back and forth to the curb to smoke and did not always sign himself out. During an observation and interview on 1/24/25 at 12:09 pm, Resident 303 indicated he was going to smoke by the curb and was observed wheeling himself down the sidewalk to the curb. Resident 303 indicated he had not signed out, so the facility would not know he was off the facility property. During an interview with the Admin on 1/24/25 at 12:45 pm, Admin indicated that it was important for the facility to know when a resident was off the facility property, and the residents should be signing out. 2. c) During an interview on 1/24/25 at 11:59 am, LN U indicated she did not know where Resident 303 kept his cigarettes or lighters. LN U indicated since they were a non-smoking facility she did not monitor the smoking equipment. During an observation and interview on 1/24/25 at 12:09 pm, Resident 303 was observed outside on the curb and pulled his lighter and cigarettes from his coat pocket and lit his cigarette. Resident 303 indicated that he kept his cigarettes and lighter with him in his room, sometimes in his coat pocket and sometimes in his pants pockets. Resident 303 indicated his friends bring him lighters and cigarettes and sometimes he goes to the store and buys them. During an interview with the Administrator (Admin) on 1/24/25 at 12:45 pm, indicated that the facility did not manage the residents smoking equipment. But indicated that they should. 2. d) On 1/24/25 a review of Resident 303's medical record identified a Smoking Evaluation (an evaluation that identified if a resident was safe with smoking and/or required equipment needed to be safe to smoke) dated 1/22/25, (14 days after admission). The document indicated Resident 303 required a smoking apron for safety when smoking. During a concurrent interview with LN V and record review on 1/24/25 at 11:50 am, LN V indicated she did not know if she should have done a smoking evaluation on admission for Resident 303, since he smoked off the facility property. During an interview with Medical Director (MD) on 1/24/25 at 11:56 am, MD indicated that this was a non-smoking facility and if a resident wanted to go off the facility grounds to smoke then we should have done a smoking evaluation on admission to see if they were safe to smoke. (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	01/24/2025

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	During an observation and interview on 1/24/25 at 12:09 pm, Resident 303 was observed by the curb and lit his cigarette and smoked. Resident 303 had a round hole in his sweatpants, and he indicated he had burned it with his cigarette a few months ago at home. Resident 303 was not wearing a smoking apron and indicated that he had never worn one. 2. e) During an observation and interview on 1/24/25 at 12:09 pm, Resident 303 indicated he was going to smoke by the curb and was observed wheeling himself down the sidewalk. As Resident 303 went rapidly down a sidewalk ramp, he took his hands off the w/c wheels and let the w/c roll forward, uncontrolled, into the facility parking lot within inches of a large pothole that was in the crosswalk lines. Resident 303 continued across another short section of facility sidewalk, through another facility parking lot, then onto the last stretch of facility sidewalk to the curb. Resident 303 indicated that sometimes the pathway to the curb was blocked by cars and he was unable to get to the curb. During an observation and interview with the Maintenance Director (MTD) on 1/24/25 at 12:40 pm, the pothole in the parking lot crosswalk was observed. MTD indicated that it was unsafe for Resident 303 to wheel close to this pothole and it should be fixed. During an interview with the Admin on 1/24/25 at 12:45 pm, Admin indicated she was unaware that Resident 303 wheeled past the pothole. Admin indicated they had been reviewing bids from different contractors to get the parking lot repaved and to fix the potholes.

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	01/24/2025

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 - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to follow their pain management policy and identify causes of pain, implement pain management strategies, and monitor or modify approaches to ensure pain was adequately controlled for one out of 4 sampled residents (Resident 76) when: Resident 76 screamed out in pain when staff changed her brief (adult diaper), because staff forced her contractured legs (a permanent and irreversible deformity of a joint caused by the muscles and tendons shortening and stiffens the joint and causes an inability to move. Forcing a contractured body part such as arms, legs or neck, to move farther than the position it is fixed in, causes severe pain, muscle damage and broken bones). This failure resulted in severe pain and anxiety during brief changes for Resident 76 and had a negative affect on her physical, mental, and emotional well-being. Findings: A review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, revised 4/1/24, indicated, facility staff would identify causes of pain, implement pain management strategies, and monitor or modify approaches to ensure pain was adequately controlled. The P&P indicated, possible behavioral signs of pain were Verbal expressions of pain, and Facial expressions such as grimacing, frowning, clenching of the jaw, etc. The P&P indicated, an increase in breathing was a possible response to pain. A review of the undated, Admission Record, indicated, Resident 76 was admitted to the facility on [DATE] and had the diagnoses of anxiety (feelings of dread or fear), unilateral primary osteoarthritis (a disease that caused a breakdown of the joints over time and often caused pain), left hip, dorsalgia (back pain), and dementia (memory loss). The Admission Record, indicated, Resident 76 received hospice care and was not her own responsible party (did not make own decisions). A review of the quarterly Minimum Data Set (MDS, an assessment tool), dated 10/15/24, Section C, indicated, Resident 76 had a Brief Interview for Mental Status (BIMS, an assessment that tested a resident's ability to recall information and memory, also known as cognition). Resident 76 scored a 1 out of 15, which indicated poor cognition. The MDS indicated, Resident 76 was dependent (staff did all of the work) on facility staff for toileting hygiene, rolling from left to right in bed, and had impairments to both lower extremities (hip, knee, ankle, foot). The MDS indicated, Resident 76 had pain and was incontinent (had no control of her bowel and bladder). (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	01/24/2025

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 - Actual harm Residents Affected - Few	During a concurrent observation and interview on 1/22/25 at 2:15 pm in Resident 76's room, Certified Nurse Assistant (CNA) D and CNA M were observed changing Resident 76's brief. Resident 76's left leg was observed to be fixed and bent at the knee and was over her chest, and tilted inwards against the right leg. CNA D confirmed, Resident 76's left leg could not move very far because she had a contracture. CNA D stated, when Resident 76's left leg was touched it was painful to her and she would scream, and cry. When CNA D and CNA M assisted Resident 76 to roll over onto her right side, Resident 76 made a moaning sound. When Resident 76 was assisted to roll onto her left side, Resident 76 had a frown on her face and said ooooooo multiple times. CNA D and CNA M then assisted Resident 76 to lying on her back. CNA D was observed forcing Resident 76's legs apart while CNA M slid the brief through the small tight opening of the legs. Resident 76 was observed screaming ow multiple times, had tears in her eyes, was breathing fast, was holding on to the bed rails tightly, and Resident 76's knuckles turned white. CNA D asked if Resident 76 was in pain. Resident 76 confirmed being in pain. CNA D and CNA M confirmed every time they changed Resident 76's brief and pulled her legs apart, it caused her pain. During an interview on 1/22/25 at 2:44 pm, Licensed Nurse (LN) R confirmed, when Resident 76 needed her brief changed it was always a painful experience for her because of her contractured legs. LN R confirmed that Resident 76 had not been evaluated for a less painful way to manage her incontinence. During an interview on 1/22/25 at 2:59 pm, CNA N confirmed anytime Resident 76's left leg was touched, Resident 76 would scream out in pain. CNA N stated, CNA N would talk to Resident 76 about deep breathing during pain, and she tolerates it. During an interview on 1/22/25 at 3:42 pm, Registered Nurse (RN) A confirmed anytime Resident 76's legs were moved, it caused her pain. RN A indicated there had been no reevaluations considered for an alternative to using briefs to manage Resident 76's incontinence. During an interview on 1/23/25 at 11:35 am, Resident 76's roommate stated every time facility staff changed Resident 76, Resident 76 would scream out in pain. The roommate added, It is heart breaking to hear and it makes me want to cry. During a concurrent observation and interview on 1/23/25 at 9:08 am in Resident 76's room, with Hospice Licensed Nurse (HLN). Resident 76 was lying on her back in bed. HLN asked Resident 76 if she could describe her pain on a scale of 0 to 10 (where zero meant no pain, and 10 meant the worst pain), Resident 76 yelled, it's a 20! HLN confirmed that he was not informed by facility staff that changing Resident 76's brief was painful and stated he was not aware that Resident 76's pain was, at this level. During an interview on 1/23/25 at 11:41 am in Resident 76's room, Resident 76 stated, It's very painful when the CNAs change her brief. (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	01/24/2025

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 - Actual harm Residents Affected - Few	During a concurrent observation and interview on 1/23/25 at 12:13 pm in Resident 76's room, Resident 76 was observed laying on her back in bed, with the head of the bed elevated. CNA D and CNA M were observed lowering the head of bed down and preparing to change Resident 76's brief. Resident 76 immediately started crying and said No! Resident 76 cried out ow, ow, ow, ow, over and over until the head of the bed was down and the bed was in the flat position. CNA M was observed placing one hand on Resident 76's left knee and the other hand on Resident 76's left shoulder and physically rolled Resident 76 onto her right side. While CNA D cleaned Resident 76's peri area (private area), Resident 76 was grimacing, crying, and stated, She just hurt me. CNA D and CNA M then rolled Resident 76 on to her back. CNA D was observed placing a brief in between Resident 76's legs, but the opening was narrow because her legs were stuck bent together from contractures and CNA D pulled on the brief harder, forcing it through Resident 76's legs. Resident 76 began screaming ow, ow, ow and no, no, no. Resident 76 was breathing heavy and had a frown on her face. Both of Resident 76's hands were holding the bed rails so tight that her knuckles were white. A review of the facility's P&P titled, Care Plans, Comprehensive, dated 8/1/24, indicated, facility staff would identify .problem areas and their causes . The P&P indicated, Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' condition change. A review of Resident 76's Pain care plan, dated 2/20/24, indicated, Resident 76 was at an increased risk to experience pain during ADL (Activities of Daily Living) care. The care plan included interventions, revised on 2/23/24 that included; assessing factors that contributed to pain, notifying the physician if there was an increase in pain, and that staff would handle Resident 76 gently when providing care. The care plan had not addressed how to manage brief changes with Resident 76's contractured legs, without causing her pain, anxiety and fear. A review of Resident 76's Bladder Incontinence and Bowel Incontinence care plan, revised on 2/23/23, had not identified that brief changes were painful to Resident 76. There were no alternative methods for managing her incontinence. During a concurrent interview and record review on 1/24/25 at 6:56 am, the Director of Staff Development (DSD) confirmed she knew Resident 76 had pain with brief changes because of the left leg being moved. DSD confirmed staff should not force Resident 76's legs apart as that caused severe pain. DSD indicated that CNAs were expected to handle Resident 76 gently, stop providing care when she expressed pain, and notify the nurse. DSD stated, by forcing the brief between Resident 76's legs could also cause skin breakdown by sheering (a wound caused by the friction of something rubbing against the skin). DSD stated, CNAs should not use their hands to reposition a resident. DSD stated staff were trained to use a draw sheet (a sheet under the resident to roll them side to side). DSD was unable to provide evidence that LN and CNA staff had received training on care of residents with contractures and pain. During a concurrent interview and record review on 1/24/25 at 8:09 am, with the DON she confirmed that she knew changing Resident 76's brief was an uncomfortable and painful experience for Resident 76. DON stated she expected the CNAs to notify the LNs when Resident 76 had pain, and for the LNs to notify the physician and DON, if the pain was not controlled. DON stated, she had not provided LNs with training regarding care of residents with contractures. (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	01/24/2025

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 - Actual harm Residents Affected - Few	During an interview on 1/24/25 at 11:16 am, the facility's Medical Director (MD) indicated that HLN had just notified him about Resident 76's pain during brief changes. MD stated, I can talk to the hospice team about problem solving. MD indicated that communication between the facility and hospice had not been effective in regard to managing Resident 76's pain and stated, it should be better.

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	01/24/2025

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 51253 Based on interview and record review, the facility failed to do a performance evaluation every year for one out of two sampled Certified Nursing Assistant's (CNA) M employee file reviews. This had the potential for CNAs not to receive ongoing education/inservices based on the outcome of their annual review. Findings: A record review of CNA M's performance evaluations indicated she had a review on 11/10/21 and 7/15/22. There were no evaluations for the years 2023 and 2024 found in her employee file. During a concurrent interview and record review on 1/24/25 at 12:02 pm, Director of Staff Development (DSD) confirmed CNA M did not have an annual performance review since 2022, and that the facility was behind on CNA annual performance evaluations.

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	01/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on observation, interview, and record review, the facility failed to ensure the safe and effective use of medications when: 1. Resident 302 found a pain pill at her bedside when she woke up. This failure caused anxiety for Resident 302 and the potential for a decline in her psychosocial and physical well-being. 2. The policy for medication storage was not implemented for two out five sampled medication carts. This failure resulted in putting residents at risk for harm from receiving expired and potentially contaminated or ineffective medications. 3. Narcotic disposal logs were inaccurately maintained, as there were missing names and signatures of licensed nurses in four out of 125 instances of narcotic disposal between 11/13/24 to 1/6/25. This failure had the potential to allow for drug diversion (when medication is taken for use by someone other than whom it is prescribed for). Findings: A review of the facility policy titled, Administering Medications revised August 2024, the policy indicated Medications are administered in a safe and timely manner, and as prescribed. 1. A review of Resident 302's Admission Record (undated), indicated Resident 302 was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty in swallowing), aphasia (difficulty with expressing or understanding written and spoken language), difficulty in walking, weakness, anxiety disorder, esophagus (tube from mouth to stomach) disease, and stroke. Resident 302 was discharged on [DATE]. A review of Resident 302's Physician's Orders, dated 1/6/25, indicated Resident 302 was on a pureed (foods that have been blended or mashed until they are smooth and easy to swallow) diet. During an interview on 1/22/25 at 9:11 am, Licensed Nurse (LN) S indicated that on 1/12/25 at 11:00 am, Resident 302 showed her a medicine cup with a pill in it and stated, someone left it by her bedside during the night. LN S indicated that Resident 302 was angry and said, no one woke me up and left the pill there. LN S confirmed the pill found had been a Norco (a narcotic pain pill), 5-325 mg (milligrams, a unit of measure). LN S confirmed that Resident 302 received Norco every 4 hours for pain at 2:15 am, 6:15 am, 10:15 am, 2:15 pm, 6:15 pm, and 10:15 pm. (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	01/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/22/25 at 11:01 am, Speech Therapist (ST) indicted that Resident 302 had a lot of anxiety about swallowing due to her diagnoses. ST relayed the conversation she had with Resident 302 on 1/12/25, I went in [Resident 302's room] about mid-morning. She [Resident 302] told me an incident about a night med [medication] nurse. The nurse came in about 2:00 am and handed her a Norco pill, Here is your pill then left. She would sleep sitting up due to her swallowing condition. She said she was still half asleep and fell asleep with the pill in her hand. She woke up and found the pill in her hand and said, 'I cannot take this on my own.' She [Resident 302] was concerned that the nurse did not stay with her, The med nurse should stay with me. During an interview on 1/23/25 at 9:33 am, Director of Nursing (DON) confirmed that LN T had taken a Norco 5-325 mg tablet into Resident 302's room during the night and had not verified that Resident 302 had taken the pill. The DON indicated that LN T should have stayed with Resident 302 until she swallowed the pill and LN T had not done that. DON and LN S identified the pill together and destroyed it as per facility policy. 50363 During an observation of Station I's medication cart on 1/21/2025 at 11:34 am, a Toujeo Solo (Insulin Pen, a device for insulin administration; insulin is injected to control blood sugar for patients with uncontrolled blood sugar), remained available for use after the expiration date 12/14/2022. Refresh P.M. ophthalmic ointment (ointment used at night to help treat dry eyes), remained available for use after the expiration date 11/25/2024. During an observation of Station 4's medication cart on 1/21/2025 at 11:34 am, Aspirin 325 milligrams (mg), remained available for use after the expiration date 12/31/2024 on a station 4 medication cart. During a review of the facility's policy titled, Storage of Medications revised August 2024, indicated, Discontinued, outdated, or deteriorated drugs or biologicals are placed in designated appropriate bins for destructions. During a review of facility's policy titled, Administering Medications revised August 2024, indicated, The expiration/beyond use date on the medication label is checked prior to administration. During an interview on 1/21/2025 at 10:30 am, Licensed Nurse (LN) S confirmed there were expired medications available for use in the medication carts and stated, I'm not sure why expired medications are in the cart. During an interview on 1/21/2025 at 2:04 pm, LN W indicated she did not know how often medication carts were supposed to be checked for expired medications. During a review of the facility's policy titled, Discarding and Destroying Medications revised October 2024, indicated, The medication disposition record will contain the following .signature of witnesses. (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	01/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of document titled, Master Narcotic Inventory Sheet, on 1/24/2025 at 2:30 pm, DON confirmed there were four licensed nurse signatures missing on the master narcotic (highly controlled substances such as narcotic pain pills) inventory sheets in either, signature of nurse receiving medication or nurse giving to DON under disposition information. DON stated facility would do better.

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	01/24/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50363 Based on observation, interview, and record review, the facility failed to be free of medication error rates of five percent (%) or greater when five medication errors were observed out of 26 opportunities. The medication error rate was 19.2 %. This failure resulted in multiple medication errors and had the potential for the residents not to receive medication as their physician's ordered. Findings: 1. A record review of facility policy titled, Administering Medications through a Small Volume (Handheld) Nebulizer revised October 2024, indicated, wash and dry hands .explain the procedure to the resident .wash and dry hands .turn on nebulizer and check the outflow port for visible mist .instruct the resident to take a deep breath, pause briefly and then exhale normally, encourage the resident to repeat the above breathing pattern until the medication is nebulized or until the designated treatment time is reached .monitor for side effects, including rapid pulse .encourage resident to cough and expectorate as needed .wash and dry hands. A review of an article found on American Lung Association, How to Use a Nebulizer dated August 1, 2024 at https://www.lung.org/getmedia/3124fe1d-abc5-4741-8c17-bc8a449ea67b/ABCs-Nebulizer-V2-4-6-2020_new-branding.pdf?ext=.pdf, indicated secure mask over face. During a record review of Resident 19's Medication Administration Record (MAR) January 2025, nebulizer assessment and treatment was 15 minutes. During an observation on 1/21/2025 at 11:52 am, Respiratory Therapist (RT) did not wash and dry her hands, did not explain the procedure to Resident 19, did not wash and dry hands a second time, and did not check the outflow port for visible mist. RT positioned the mask on the Resident 19's left side of her mouth and cheek and turned around. Visible mist was observed and escaped the top of the mask for three minutes. RT still had her back turned to the resident. RT did not instruct Resident 19 on the proper breathing pattern. RT did not monitor for side effects with a pulse oximeter (a device put on a finger that measures amount of oxygen in the blood), or for a rapid pulse. RT did not encourage Resident 19 to cough and expectorate (spit) as needed. RT turned around and held the mask on Resident 19's face for the remainder of the treatment. Resident 19 complained medication was not effective from a prior treatment that morning. This was the second treatment of the morning. During a concurrent interview on 1/21/2025 at 12:37 pm, RT stated facility masks did not have a metal nose fitting to fit snug on residents' noses. RT stated she had not requested facility order masks with metal piece in nose part of mask. RT stated she did not notice Resident 19's mask was on the left side of her mouth and cheek. RT stated she did not notice that medication had escaped from the top of the mask for three minutes. RT stated if residents moved their heads, the mask went crooked. RT stated she knew mask needed to be properly placed and fitted to ensure resident received entire nebulizer treatment. RT acknowledged the mask did not fit on Resident 19's face and medication escaped. (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	01/24/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of facility's policy titled, Administration of Eye Drops revised August 2024, indicated part of the required equipment included gloves. The policy also indicated to, have resident tip his/her head back slightly, pull the lower eyelid down and away from the eyebacll to form a pocket, hold the dropper tip directly over the eye, taking care to avoid touching the eye or eyelid. Instruct resident to look upward, place one drop into the pocket .release the eyelid and instruct the resident to close the eye slowly and keep it closed .wash your hands. A review of facility's policy titled, Administering Medications revised August 2024, indicated, staff follows established facility infection control procedures for the administration of medications, as applicable. A website review of https://www.combigan.com/patient/getting-started 2023 indicated manufacturer best practice stated on step four to close the eyes and lightly press on inside corners of the eyes. During an observation on 1/22/2025 at 7:41 am, Licensed Nurse (LN) R did not have Resident 34 look up and did not instruct Resident 34 to close his eye. LN R did not hold the inner canthus (corner) of Resident 34's eye after administration. LN R did not wash his hands after medication administration was completed. During an interview on 1/22/2025 at 12:28 pm, LN R stated he forgot about the facility eye drop administration policy and confirmed he had not held the inner canthus of Resident 34's eye, after he administered the drops. During an observation on 1/22/2025 at 7:44 am, of LN Q giving Resident 68 eye drops. LN Q did not wear gloves. LN Q did not have the resident look up and did not instruct the resident to close her eyes. LN Q did not hold the inner canthus of either eye, after administration. LN Q did not wash her hands after she administered the eye drops. During an interview on 1/22/2025 at 12:25 pm, LN Q confirmed she did not follow facility eye drop administration policy for Resident 68, because it was the resident's preference. During an interview on 1/22/2025 at 12:26 pm, Resident 68 confirmed the LNs do not touch her inner canthus when they administer her eye drops. Resident 68 stated staff never educated her on facility eye drop administration procedure. Resident 68 stated she wanted facility staff to administer her eye drops per facility policy and manufacturer guidelines. During a concurrent interview on 1/22/2025 at 12:43 pm, Director of Nursing (DON) stated facility expectation was for staff to wear gloves when administering eyedrops and nasal sprays. DON stated staff was just educated with competencies. DON stated she was unaware manufacturer professional standard of practice was to hold inner canthus of resident after eye drop administration. During an observation on 1/22/2025 at 7:57 am, Registered Nurse (RN) B left Resident 130's room before he swallowed six medications that she handed to him in a cup. RN B handed Resident 130 the medication cup, offered to sit him up and left. Resident 130 declined to sit up and swallowed medications laying on his side. During an observation on 1/22/2025 at 9:14 am, LN Y documented he administered a packet of Metamucil (a fiber laxative), to resident, but he had not. (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	01/24/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and review of the medication administration record (MAR) on 1/22/2025 at 9:30 am, LN Y confirmed he documented that he had administered Metamucil to resident but did not administer it. LN Y stated he would go back to the MAR and make the correction. LN Y confirmed this action as a medication error and stated, that shouldn't have happened. During an interview on 1/23/2025 at 1:38 pm, DON indicated staff needed to improve on medication administration competencies.

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	01/24/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50363 Based on observation, interview, and record review, the facility failed to properly store medications in two out of two sampled medication storage rooms. Disorganized storage of medications in a nursing home can lead to medication errors, delays in treatment, and potential adverse health effects. Findings: During a review of facility policy titled, Storage of Medications reviewed August 2024, indicated, The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Facility policy further indicated, Medications are stored separately from food and are labeled accordingly. During a website review of the American Society of Consultant Pharmacists https://www.ascp.com/page/policystatements 2016-2024, indicated medications must be stored separately from non-prescription items, including enteric food (liquid food that goes directly into the intestines and bypasses the stomach), and alcohol swabs to prevent contamination and reduce the risk of medication errors. During an observation on 1/21/2025 at 3:22 pm, medication room number three was found to have medications that were not expired stored in the medication discard cabinet alongside expired medications and those intended for an incoming resident admission. In a concurrent interview at 3:30 pm, Licensed Nurse (LN) X stated that medication storage rooms are checked and maintained by facility supervisors, but was uncertain about the frequency of these checks. During an observation on 1/22/2025 at 2:41 pm, medication room number one had enteric food supplies next to probiotics (medicine for intestinal tract), multivitamins, and alcohol swabs. There were also wooden sticks and gauze next to over-the-counter medications (medications anyone can buy at the store) in the same cabinet. The cabinet also contained a current resident's mail package, unlabeled. During a concurrent interview on 1/23/2025 at 1:21 pm, the Director of Nursing (DON) acknowledged the disorganization in the medication room and stated that, following the findings of the survey team, the facility had reorganized the medication room cabinets. She emphasized that they will make improvements and do better moving forward.

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	01/24/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49418 Based on observation, interview, and record review, the facility failed to ensure: 1. Resident 98's perishable food was stored in the refrigerator rather than at his bedside, and his expired food was discarded. 2. Descaling (the process of removing a hard, white layer of limescale - a hard chalky buildup of calcium left over from water - from an object) and sanitizing (a process to reduce the number of microorganisms to safe levels) of the ice machine was performed per the manufacturer's instructions. These failures had the potential: 1. To place Resident 98, a medically vulnerable resident, at risk for foodborne illness related to the growth of microorganisms (bacteria or fungus that cause nausea, vomiting, and diarrhea). 2. For the facility ice machine to become contaminated with microorganisms, putting all residents consuming ice from the ice machine at risk for foodborne illness. Findings: 1. A review of the facility's Policy and Procedure (P&P) titled, Foods Brought by Family/Visitors, dated 2001, indicated food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. The P&P indicated: A. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that is clearly distinguishable from facility-prepared food. I. Nonperishable foods are stored in resealable containers with tight-fitting lids. Intact fresh fruit may be stored without a lid. II. Perishable foods are stored in resealable containers with tightly fitting lids in the refrigerator. Containers are labeled with the resident's name, the item, and the use by date. B. The nursing or food service staff will discard perishable foods on or before the use by date. C. The nursing and/or food service staff will discard perishable foods that show obvious signs of potential foodborne danger, for example mold growth, foul odor, or past-due package expiration dates. D. Potentially hazardous foods that are left out for the resident without a source of heat or refrigeration longer than two hours are discarded. (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	01/24/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 98's Admission Record indicated Resident 98 was admitted on [DATE] with diagnoses of stroke, need for assistance with personal care, poor nutrition status, depression, malignant (uncontrolled spread of) prostate cancer, a pacemaker (an artificial device that regulates heart muscle contractions), and chronic obstructive pulmonary disease (COPD, constriction of the airways making it difficult or uncomfortable to breathe). During observation of Resident 98's room on [DATE] at 8:26 am, observed Resident 98 eating breakfast in bed. Resident 98's bedside table contained three opened jars: sweet pickles, salsa, and strawberry jam (jam with expiration date [DATE]) without opened on or use by dates. The jars were room temperature to touch. A box next to the bed contained two bottles of partially consumed, murky, pale white-yellow liquid with sediment at the bottom, the manufacturer label indicating tonic water, both room temperature to touch; a nearly empty, room temperature jar of mayonnaise; an opened jar of peanut butter; an opened bottle of hot sauce, room temperature to touch; an opened container of spicy brown mustard, room temperature to touch; a styrofoam cup with a wet paper towel in the bottom containing withering green onions; a package of chewing tobacco; a container of odor-free emu oil formula; and a plastic tube of cortisone cream. None of the opened food items were labeled with opened on or use by date. A bag containing several pieces of toast was observed on the floor at Resident 98's bedside. Resident 98 stated he liked to keep snacks near his bed. During concurrent observation of Resident 98's room and interview on [DATE] at 8:41 am, Certified Nurse Assistant I (CNA) I stated staff try to keep resident foods put away in the drawers. CNA I stated, We've all tried with [Resident 98] to get him to put his food in the refrigerator. He won't let us take it, and he has rights. CNA I stated, Facility policy is that refrigerated food should have names, dates, and be put in the resident refrigerator. CNA I stated resident food should be consumed in two days after opening. CNA I acknowledged the strawberry jam at bedside should have been refrigerated. CNA I again stated that she and Social Services staff have asked to put Resident 98's food in the refrigerator, but Resident 98 won't allow it. On observation, the salsa manufacturer's label indicated to promptly refrigerate after opening. The spicy brown mustard, mayonnaise, jam, and sweet pickles manufacturer labels indicated to refrigerate after opening. During concurrent observation of the resident refrigerator on Station 2 (nearest Resident 98's room) and interview with CNA I on [DATE] at 8:52 am, signage on the refrigerator door indicated resident food should be labeled and dated and consumed within three days of opening. CNA I stated, I was wrong. I thought they had two days to eat it, but they have three. Personal food labeled for use by Resident 98 was not observed in the refrigerator. During observation of Resident 98's room on [DATE] at 8:44 am, the mayonnaise, spicy mustard, pickles, salsa, expired jam, hot sauce, peanut butter, tonic water, and withered green onions remained at the bedside or on the nightstand. None of the items were labeled by staff with opened on or use by date, and all were room temperature to touch. During an interview with the Infection Prevention Registered Nurse (IP/RN) on [DATE] at 9:41 am, IP/RN stated expired and perishable foods should not be kept at the bedside. IP/RN stated the expectation would be that food containers be labeled with an open date and should be refrigerated if the manufacturer label indicated to do so. IP/RN stated Resident 98 has a care plan for it but noted we are in the process of cleaning everything out of his room and that could be why they (perishable foods) are out. IP/RN stated Resident 98 is pretty particular. (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	01/24/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 98's Care Plan, dated [DATE], indicated: Resident 98 prefers to have personal belongings within easy reach, creating clutter: seasoning packets, napkins, food, utensils, dental hygiene, and bowls, initiated [DATE], revised [DATE]. Goal: Educate Resident 98 on the importance of keeping area clean, initiated [DATE], revised [DATE], target date [DATE]. Interventions, initiated [DATE], included encouraging resident about importance of cleanliness and hygiene, encouraging the use of call light for assistance, and positive feedback for good behavior; emphasize the positive aspects of compliance. A review of Resident 98's Behavior care plan indicated Resident 98's room is often cluttered with personal belongings/packages/variety of snacks on the floor and chair, along with multiple personal items across his side table and nightstand. Resident 98 continues to order items online and display behaviors of hoarding in his room. Staff to encourage resident to declutter and minimize items kept. Initiated and revised on [DATE]. Goal is for staff to monitor for changes in behavior and effectiveness of interventions, initiated [DATE], target date [DATE]. Interventions included focused behaviors, initiated [DATE], and encourage [Resident 98] to keep area clean, initiated [DATE]. 43755 2. During an interview with Maintenance Director (MTD) and Maintenance Assistance (MTA) on [DATE] at 9:45 am, MTA indicated they had a Manitowoc ice machine model number IT0420. MTA was asked what product was used to descale and sanitize their Manitowoc ice machine. MTA presented a product made by Essential Values titled Essential Values Ice Machine cleaner and descaler and a product made by Nu-Calgon titled IMS-III Sanitizing Concentrate and indicated that these were the products that were used. On [DATE] at 9:47 am, an interview with the MTD and MTA, and a review of the Manitowoc ice machine manufacture instructions titled Manitowoc Indigo NXT Ice Machines Installation, Operation and Maintenance Manual dated [DATE], was performed. The manufactures instructions for de-scaling and sanitizing the ice machine in section 4 of the manual indicated Use only Manitowoc approved Ice Machine De-scaler and Sanitizer for this application (Manitowoc De-scaler part number 9405463 and Manitowoc Sanitizer part number 9405653). MTA indicated that they were not using the Manitowoc De-scaler or Sanitizer and that they were using the wrong solutions according to the manufacturer's instructions. During an interview with the Registered Dietitian (RD) on [DATE] at 7:37 am, RD indicated that the descaling and sanitizing should be done according to manufacture instructions and were not.

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	01/24/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on observation, interview, and record review, the facility failed to ensure an infection prevention program was maintained to prevent the spread of infection when: 1. The wheelchairs (W/Cs) for Residents 1, 2, 13, 46, and Resident 133 were visibly unclean and soiled. 2. The oxygen tubing for Resident 72 was not stored appropriately while not in use. 3. Personal hygiene products were not stored properly for Resident 62 and Resident 133. 4. An unkept and worn elevated bedside commode was used for Resident 87. 5. Certified Nursing Assistant (CNA) B did not perform hand hygeine after touching self during a dining observation. These failures had the potential for the spread of infection throughout the facility to each client which could lead to negative clinical outcomes including transmission of food borne illness. Findings: 1. A review of the facility's policy revised 8/2024, titled, Cleaning and Disinfection of Environmental Services, indicated resident-care equipment, including reusable items, and durable medical equipment (DME) will be cleaned, according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA) bloodborne pathogens standards. Reusable items, including environmental surfaces will be cleaned and disinfected between residents and when surfaces are visibly soiled. DME must be cleaned before reuse by another resident. During an observation on 1/21/25 at 8:55 am, the W/C for Resident 1 including the footrests were unclean, with dried yellow and tan colored food substances, dried food crumbs and cumulative dust and grime. The W/C cushion was visibly soiled with tan colored food substances, and food crumbs. During an observation on 1/21/25 at 9:13 am, the W/C for Resident 46 was unclean with dried, tan colored food substances, dried food crumbs and cumulative dust and grime. The W/C cushion was visibly soiled with tan colored food substances, and food crumbs. During an observation on 1/21/25 at 9:33 am, the W/C including both arm rests for Resident 133 was unclean with dried, cumulative dust and grime. The W/C footrests were covered in dark dried black spots, and cumulative dust and dried food particles. During an observation on 1/21/25 at 9:49 am, the W/C including the arm rests, footrests, and wheels for Resident 13 was unclean with dried, cumulative dust and grime. The W/C cushion was visibly soiled with dried food particles. (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	01/24/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/21/25 at 3:18 pm, the Housekeeping Supervisor (HS) confirmed the W/Cs and cushions need to remain clean for all residents for infection control. HS stated, Sometimes we have to wait until the residents are back in bed to clean, but I confirm the W/Cs are dirty and need to be cleaned for all residents. During an interview on 1/22/25 at 2:42 pm, the Director of Nursing (DON) confirmed the W/Cs and cushions were not clean on the long-term hall for Residents 1, 13, 46, and Resident 133. During an interview on 1/22/25 at 2:45 pm, the Administrator (Admin) confirmed the W/Cs and cushions were not clean for Residents 1, 13, 46, and Resident 133. During an observation on 1/24/25 at 8:30 am, the W/C and cushion for Resident 2 were visibly soiled with dried food particles and a yellow-colored dried substances. During a concurrent observation and interview on 1/24/25 at 8:46 am, Licensed Nursed (LN) R confirmed the W/C and cushion for Resident 2 had dried food particles and needed to be cleaned. LN R stated, Yes, I confirm all the W/Cs and cushions need to be cleaned on a regular basis for all the residents because they need to sit in a clean chair for infection control. During a record review dated December 2024, titled, Wheelchair Wash Log and Inspection, indicated the W/C and cushion cleanings for all residents in the facility documented. The last date the W/C and cushions were cleaned for Residents 1, 2, and Resident 46 was 12/3/2024. The last date the W/Cs and cushions were cleaned for Resident 13 and Resident 133 was 12/4/2024. During this wheelchair log review, it was indicated there were no logs for October 2024, November 2024, and January 2025. 2. A review of the facility's policy revised 10/2024, titled, Oxygen Administration, indicated to verify there is a physician order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Oxygen therapy is administered by way of an oxygen mask (device held in place by an elastic band around the resident's head), nasal cannula (n/c, an oxygen tube placed in the resident's nose). The oxygen tubing is changed at least weekly and stored in anti-microbial bag which is changed at least every 30 days. During a review of Resident 72's medical record, the Admission Record, indicated Resident 72 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstruction Pulmonary Disease (COPD, a progressive lung disease), chronic respiratory failure with hypoxia (low oxygen levels in the blood), dysphagia (difficulty swallowing), and heart disease. During a review of Resident 72's medical record, a document dated January 2025, titled, Order Summary Report, indicated oxygen was ordered at 2 liters/minute via n/c routine to maintain oxygen levels greater than 90%. Oxygen at 2 liters via n/c every shift for COPD. During an observation on 1/21/25 at 12:00 pm, the oxygen tubing was lying on the floor for Resident 87 when he was in the dining room. Certified Nursing Assistant (CNA) D confirmed the oxygen tubing should be stored in an anti-microbial bag on the bedside table when Resident 87 is not in bed. During an observation on 1/24/25 at 7:15 am, the oxygen tubing for Resident 87 was lying on the floor, not stored in the anti-microbial bag. (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	01/24/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/24/25 at 7:30 am, the Director of Nursing (DON) removed the dirty oxygen tubing on the floor for Resident 87 and confirmed the oxygen tubing should be placed in the anti-microbial bag when not in use. 3. A review of the facility's policy revised 6/2023, titled, Infection Prevention and Control Program, indicated An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable (contagious illnesses) diseases and infections. The IPCP is developed to address the facility-specific infection control needs and requirements identified in the facility assessment and the infection control risk assessment. The program is reviewed annually and updated as necessary. The program is based on accepted national infection prevention and control standards. During an observation on 1/21/25 at 11:04 am, the incontinent pads for Resident 62 were out of the package, not covered and lying inside the dresser shelves. During an interview on 1/22/25 at 3:25 pm, CNA L confirmed the incontinent pads for Resident 62 should be stored in a plastic bag and should be inside a dresser, not lying on the shelves. CNA L stated, Sometimes noc shift leaves them out if they are in a hurry, but that is not how we were trained. During an observation on 1/21/25 at 3:01 pm, personal hygiene wipes were sitting beside Resident 133's glass of water on the bedside table. During an interview on 1/21/25 at 3:10 pm, CNA L confirmed the personal hygiene products should never be stored on a bedside table for any resident and sitting beside any food or water. During an interview on 1/22/25 at 3:00 pm, the DON confirmed all personal hygiene products should be stored separately from any food or water, and all incontinent pads should be covered and stored inside the furniture. 4. During an observation on 1/21/25 at 3:16 pm, the elevated commode in Resident 87's bathroom was covered in unremovable rust-colored areas including the legs, arm rests and had chipped white paint. During an interview on 1/21/25 at 3:30 pm, the HS confirmed there was multiple areas of unremovable rust, and the elevated commode used by Resident 87 needed to be replaced. HS stated, I will change that out right now, I did not know it was rusty, we have more elevated commodes in storage. 45315 5. During an observation on 1/21/25 at 12:22 pm, CNA B was observed passing out lunch trays in the main dining room. CNA B was assisting multiple residents prepare to eat their lunch by opening milk cartons, taking lids off bowls and plates, and opening packets of salt and pepper. CNA B was observed touching her face, in between assisting residents without washing her hands. During an observation on 1/21/25 at 12:28 pm, CNA B was observed touching her face, reaching into the tray cart (where resident meals were stored), and removing a lunch tray. CNA B assisted a resident prepare to eat lunch without washing her hands after touching her face. (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	01/24/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/21/25 at 12:36 pm, CNA B stated, CNA B was unaware that she had touched her face during the dining observation. CNA B stated, hand hygiene should be performed in between each meal tray that was passed and after touching self. During an interview on 1/24/25 at 9:19 am, Infection Preventist (IP) stated, facility staff were expected to sanitize hands after touching their face, prior to serving residents their meals.

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	01/24/2025

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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. 43755 Based on observation, interview, and record review, the facility failed to ensure policies were established and implemented regarding smoking safety for one of two sampled residents (Resident 303) when: 1. Resident 303 smoked on the sidewalk in front of the facility and the facility had not identifed him as a smoker because the facility had no policy or procedure to identify residents who smoked while off the facility property. 2. Resident 303 kept his cigarettes and lighters in his room unsecured because the facility had no policy or procedure to identify and manage resident smoking materials (cigarettes and lighters) for residents that smoked while off the facility property. 3. Resident 303's clothes had a cigarette burn holes (from smoking at home), but was not monitored for safety because the facility had no policy or procedure to do a smoking evaluation on residents who smoked off the facility property to ensure they were able to smoke safely. These failures resulted in an unsafe environment for Resident 303. Findings: A review of the facility's policy titled, Non-Smoking Policy-Residents dated January 2024, the policy indicated This facility is a non-smoking facility but has grandfathered (a resident who was allowed to smoke before the new policy was put into practice was still allowed to smoke on the facility property under the new policy) one resident into the prior smoking policy. 1. Prior to, and upon admission, residents are informed of the facility non-smoking policy. 2. Smoking is only permitted by residents (other than the one individual grandfathered into prior smoking policy) off property. 1. On 1/21/25 at 8:08 am, during the entrance conference, the Administrator (Admin) indicated that the facility was a non-smoking facility except for one resident (Resident 17) that was grandfathered in to smoke on campus. Admin indicated that anyone admitted after smoking on campus ended, they had to sign out and smoke off the grounds. The Admin indicated she was unsure who smoked off the facility property because there was no list of residents who smoked off the facility property. During an interview and observation on 1/21/25 at 8:44 am, Resident 303 was sitting in his wheelchair (w/c) in the facility hallway. Resident 303 indicated that he was a smoker and since this was a non-smoking facility, he would wheel out to the sidewalk to smoke. During an interview on 1/21/25 at 9:00 am, Licensed Nurse (LN) W indicated Resident 303 was a smoker and went outside to the curb to smoke. A review of Resident 303's, Nursing-Admission/Readmission Evaluation/Assessment (NAREA) dated 1/8/25, indicated LN V documented Resident 303 as a non-smoker. (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	01/24/2025

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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview with LN V and record review on 1/24/25 at 11:50 am, Resident 303's NAREA was reviewed. LN V confirmed that Resident 303 was a smoker, but she documented on the assessment that he was not a smoker because she thought since this was a non-smoking facility, she should identify all residents as non-smokers. During an interview with the Administrator (Admin) on 1/24/25 at 12:45 pm, Admin indicated that Resident 303 should have been identified as a smoker so the facility could provide the appropriate safety and care needed. Admin reviewed the policy and indicated their policy did not speak to this. 2. During an interview on 1/24/25 at 11:59 am, LN U indicated she did not know where Resident 303 kept his cigarettes or lighters. LN U indicated since they were a non-smoking facility she did not monitor the smoking equipment. During an observation and interview on 1/24/25 at 12:09 pm, Resident 303 was observed outside on the curb and pulled his lighter and cigarettes from his coat pocket and lit his cigarette. Resident 303 indicated that he kept his cigarettes and lighter with him in his room, sometimes in his coat pocket and sometimes in his pants pockets. Resident 303 indicated his friends bring him lighters and cigarettes and sometimes he goes to the store and buys them. During an interview with the Administrator (Admin) on 1/24/25 at 12:45 pm, indicated that the facility did not manage the residents smoking equipment. But indicated that they should. Admin reviewed the policy and indicated their policy did not speak to this. 3. On 1/24/25 a review of Resident 303's, Smoking Evaluation (an evaluation that identified if a resident was safe with smoking and/or required equipment needed to be safe to smoke) dated 1/22/25, was done 14 days after Resident 303 was admitted . The Smoking Evaluation now indicated Resident 303 required a smoking apron for safety from burns, when smoking. During a concurrent interview with LN V and record review on 1/24/25 at 11:50 am, LN V indicated she did not know if she should have done a smoking evaluation on admission for Resident 303, since he smoked off the facility property. During an interview with Medical Director (MD) on 1/24/25 at 11:56 am, MD indicated that this was a non-smoking facility and if a resident wanted to go off the facility property to smoke then, we should have done a smoking evaluation on admission to see if they were safe to smoke. During an observation and interview on 1/24/25 at 12:09 pm, Resident 303 was observed by the curb and lit his cigarette and smoked. Resident 303 had a round burn hole in his sweatpants, and he indicated he had burned his pants with his cigarette a few months ago (at home). Resident 303 was not wearing a smoking apron and indicated that he had never worn one.