

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Arbor Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on record review and interview, the facility failed to ensure the individual designated as the Dietary Manager met the qualifications required to direct food and nutrition services, including certification as a Dietary Manager or other qualifying credentials for one of one dietary managers. This failure had the potential to result in all residents receiving food and nutrition services that were not provided in accordance with professional standards. Findings: California Health and Safety Code, 1265.4 describes the staff qualifications for the day-to-day management of dietetic services in a skilled nursing facility. The Health and Safety Code describe, in the absence of a full-time Registered Dietitian with supervisory responsibilities for dietetic services, the licensed facility shall employ a full-time qualified dietary services supervisor. There are 7 recognized pathways, all of which are based on a variety of educational experiences. During a review of the facility Dietary Supervisor (referred to as Dietary Manager [DM]) employee file, signed by the DM and dated 1/26/24, the Job Description: Dietary Supervisor, indicated the position required graduation from an approved dietary manager course that meets state and federal regulations, maintenance of all required continuing education, and remaining in good standing with the Department of Public Health Licensing and Certification Division (CDPH), at all times. During a review of the DM's employee file, signed by the DM and the Registered Dietitian (RD), dated 1/12/26, the Food Service Supervisor CDM, DM Competencies, indicated that maintaining her Certified Dietary Manager (CDM) had not been met. During a review of the DM's employee file, signed by the DM and the RD, dated 5/29/26, the Performance Evaluation, indicated that completion of the CDM certification was identified as an opportunity for improvement, and the DM listed completing the CDM certification as a current work goal in the self-evaluation. During the initial tour of the kitchen on 7/6/26 at 6:05 am, and a concurrent interviews with the DM and the RD, the DM stated that they were not currently a CDM, were enrolled in a certification program, and had not yet completed it. The RD indicated they were the facilities only RD for the 144-bed facility and were responsible for daily clinical rounds, staff and services, new admissions (approximately 5 to 11 per week), weight meetings, and quarterly and annual assessments. The RD indicated they spend 50 percent (%) of their time performing clinical duties and 50% of their time in the kitchen, equating to 20 hours per week providing kitchen oversight. During an interview on 7/8/26 at 9:21 am, with the DM, the DM indicated they had served in the position since 2023. The DM stated their responsibilities included overseeing the day-to-day kitchen operations, ordering supplies, labeling and dating food, maintaining inventory and cleaning logs, managing resident food preferences, and completing meal rounds with residents. The DM indicated all job duties were overseen by the RD. The DM further indicated they were informed upon accepting the position that obtaining this CDM credential was required to qualify for the position, that no timeline was established for completing the certification, and that the expectation was that the CDM certification (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	would be completed.During an interview on 7/8/26 at 9:55 am, with the facility Administrator (Admin), the Admin indicated that the DM job description requires the DM to hold a CDM credential and that the expectation is for the DM to complete the CDM certification by the end of this month.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to maintain refuse (garbage) and debris (bits of trash) in a manner that minimized pests harborage (safe shelter, protection and suitable conditions to live, breed and thrive), by allowing trash receptacles to overflow, remain uncovered, and become soiled with food debris, and by permitting discarded remodeling materials and equipment to accumulate on the premises. This failure increased the risk of pest harborage and contamination, affecting all residents, staff, and visitors within the facility. Findings: A review of the United States Department of Agriculture (USDA) food code S 5-501.113, Covering Receptacles, indicated that refuse, recyclable, and returnable receptacles and waste handling units kept outside the food service establishment must be maintained with tight fitting lids and doors. A review of the USDA food code S 5-501.115, maintaining refuse areas and enclosures indicated that, refuse storage areas and enclosures must be kept clean and free of unnecessary items. During a review of the facility's policy and procedure titled, Miscellaneous Area, dated 2023, indicated, that food waste must be disposed of to prevent a nuisance; garbage and rubbish must be stored in clean, vermin proof areas; trash receptacles and surrounding areas must be inspected daily to ensure lids are closed in the area as free of debris; trash collection areas must be kept clean to prevent vermin and rodents; trash bins must be exchanged periodically for cleanliness when serviced by a commercial waste provider; and that flies are recognized as carriers of disease and a threat to sanitation standards. During a concurrent observation and interview on 7/6/26 at 9:30 am, with the Maintenance Director (MAIN) outside at the facility waste storage area, observed were two overflowing trash dumpsters with lids unable to fully close, an organic waste bin with excessive dried food debris and flies, discarded toilets, nightstands, and beds. The MAIN indicated the discarded remodeling materials had remained in the area for more than a month, acknowledged that they had remained there longer than considered timely (a couple of weeks), and confirmed the overflowing refuse, flies and accumulated debris, and flies created the potential for pest harborage.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, interviews, and record review the facility failed to ensure menus and portions sizes were followed for 21 of 118 residents when pureed foods were not prepared according to the menu instructions and the wrong portion size was served for soft and bite sized vegetables. This failure placed residents at risk of receiving meals that did not meet the planned nutritional standards, potentially affecting nutritional intake and dietary consistency. Findings: During a review of the facility Diet Order Tally Report, dated 7/7/26, the report indicated that 118 residents received food prepared in the kitchen, including four residents receiving puree diets. During a review of the facility's policy and procedure (P&P) titled, Portion Control, dated 2025, indicated, that food must be portioned according to the menu using the appropriate portion-control equipment. The policy specified that scoop sizes are identified by number and listed in the menu recipe books and menu spreadsheet, and that staff are to use the designated portion-control equipment when serving food. During review of the facility recipe titled, Recipe: Pureed (IDDSI Level #4) Vegetables, dated 2025, indicated, food was to be pureed to a paste consistency before adding liquid. Warm low-sodium broth or milk was to be added gradually only if needed, and thickener was to be added after pureeing to achieve the appropriate consistency. During review of the facility recipe titled, Recipe: Pureed (IDDSI Level #4) Casserole (which was used for the chicken), dated 2025, indicated, vegetables are to be pureed to a paste consistency before adding liquid. Warm low-sodium broth or milk was to be added gradually only if needed, and thickener was to be added after pureeing to achieve the appropriate consistency. During a review of the facility document titled Food and Nutrition Service In-Service - Topic - IDDSI, Diets, Liquid, Texture testing methods, dated 9/15/25, indicated the Facility [NAME] (FC) did not attend the in-service. During review of the facility menu titled, Summer Menus, dated 7/7/26, indicated, the soft and bite size baked zucchini was to be served as a 1/2 cup (#8 scoop) portion for the regular diet. During an observation on 7/7/26 at 10:05 am, in the kitchen during food preparation, the FC was observed preparing pureed Italian chicken using broth that was not low-sodium. The FC added an unmeasured amount of the broth until it reached puree consistency. During an observation on 7/7/26 at 10:15 am, in the kitchen during food preparation, the FC was observed preparing pureed zucchini using broth that was not low-sodium. The FC added the broth before blending the vegetables, after which thickener was added to achieve the appropriate consistency. During an observation on 7/7/26 at 11:50 am, in the kitchen during tray line, the FC was observed using a 1/3 cup (#12 scoop) to serve the soft and bite size baked zucchini for the regular diet instead of the 1/2 cup (#8 scoop) specified on the menu. During an interview on 7/8/26 at 9:21 am, with the Registered Dietician (RD), the RD confirmed recipes are expected to be followed, including using low-sodium broth as specified and adding liquid to pureed vegetables only after the vegetables have been pureed, if needed. The RD stated employee competency is evaluated following in-services through verbal responses or direct observation of task performance. During an interview 7/9/26 at 11:06 am, with the facility Dietary Manager (DM), the DM confirmed that the bite size zucchini for the regular diet was served using a 1/3 cup (#12 scoop) instead of the 1/2 cup (#8 scoop) specified on the menu.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food safety and sanitation guidelines were followed in the kitchen when:1. Proper hand hygiene was not performed.2. Cross contamination was observed during food prep.3. Plastic plate covers were worn with rough, uncleanable surfaces.These failures posed a risk for foodborne illness in 118 residents who received food prepared in the kitchen.Findings:During a review of the facility Diet Order Tally Report, dated 7/7/26, the report indicated that 118 residents received food prepared in the kitchen.1.During a review of the facility's policy and procedure (P&P) titled, Glove Use Policy, dated 2023, indicated, that hands must be washed before applying gloves and before donning a new pair. Gloves must be changed between tasks, after handling raw meat, when torn or soiled, after potential contamination, and at least every four hours during continual use.During a review of the facility's P&P titled, Hand Washing Procedure, dated 10/2026, indicated, that hand washing is essential to prevent he spread of infection and should be performed using soap and warm water before beginning work in the kitchen, before and after handing food, after handling soiled dishes and utensils, and after touching a trash can or its lid.During an observation on 7/7/26 at 10:05 am, in the kitchen during food preparation, the Facility [NAME] (FC) was observed removing gloves and donning (putting on) a new pair on four separate occasions without washing his hands between glove changes.During an observation on 7/7/26 at 10:33 am, and again at 11:55 am, in the kitchen during food preparation, the Dietary Aide (DA) was observed removing gloves, touching the trash can, and donning a new pair of gloves without washing her hands between glove changes.2. During a review of the facility's P&P titled, Food Handling, dated 2023, indicated, that food must be prepared and served in a safe and sanitary manner, personnel must wash their hands before handling food and before and after handling raw meat, bare-hand contact with food is prohibited, gloves must be changed before handling washed or ready to eat food items, and suitable utensils or single use gloves must be used when handling food.During an observation on 7/7/26 at 10:15 am, in the kitchen during food preparation, the FC was observed preparing food on a countertop that appeared unclean, was cluttered, and had the presence of food crumbs. On two occasions the FC was observed returning cooked meat to the cutting board after touching the meat to a portion guide mounted on the wall. During food preparation, the FC was observed flipping the cutting board over and continuing food preparation after the opposite side of the cutting board had been in contact with the countertop surface. The FC was observed going to the dish machine (dishwasher) and returning to the food preparation area without performing proper hand hygiene. The FC was observed pulling aluminum foil from the box, folding it against his clothing before using it to cover vegetables, and touching the scale controls before handling cooked zucchini with the same gloved hand.During an observation on 7/7/26 at 11:45 am, in the kitchen during tray line, the FC was observed touching his face and continuing to serve food without changing gloves or performing hand hygiene.3. During a review of the facility purchase documentation, dated 5/26/26, indicated three sets of 24 plastic plate covers were ordered on 5/20/26 and received on 5/29/26. During a concurrent observation and interview on 7/6/26 at 6:37 am, with the Dietary Manager (DM) in the kitchen, observed were six plastic plate covers that were heavily marred with thick white residue, creating rough, uncleanable surfaces. The DM confirmed the plate covers had rough surfaces, acknowledged they needed to be replaced, and stated new plate covers had been ordered but not all old covers had been removed from use yet.During an interview on 7/8/26 at 9:21 am, with the Registered Dietician (RD), the RD confirmed kitchen staff are expected to perform proper hand hygiene between glove (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	changes and after touching contaminants, such as trash or the face. The RD further confirmed that using a cluttered food preparation service, flipping a cutting board after it had contacted the soiled countertop and continuing food preparation, and returning food to the cutting board after it had contacted a size reference guide posted on the wall were all examples of cross contamination. The RD indicated employee competency is evaluated following in-services through verbal responses or direct observation of task performance.		

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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** Based on interview, facility policy, and record review, the facility failed to ensure the procedures for reporting alleged abuse were implemented when Licensed Nurse (LN) O did not report an allegation of abuse for one of 29 Residents (Resident 63), immediately or within 2 hours to the California Department of Public Health (CDPH), Ombudsman (resident advocacy group), local law enforcement and the facility Administrator. This resulted in a delay in protecting Resident 29 from further abuse and had the potential to delay investigations and protection of all residents from ongoing abuse and mistreatment. Findings: A review of the facility's policy and procedure titled, Abuse Investigation and Reporting, dated 10/2024, indicated under Reporting Line 1 Alleged violations involving abuse. will be reported to the facility Administrator, or his/her designee, and may be reported to the following persons or agencies, as required by regulation/law: a. the State licensing/certification agency responsible for surveying/licensing the facility; b. the local/State Ombudsman; d. Adult Protective Services; e. Law Enforcement. Line 2 indicated, An alleged violation of abuse. will be reported immediately, but not later than, Line A two hours if the alleged violator involves abuse. A record review of Resident 63's admission Report dated 7/9/26, indicated Resident 63 was admitted on [DATE] with diagnoses that included amyotrophic lateral sclerosis (ALS, a progressive, disorder affecting the brain, spinal cord, and nerves throughout the body), hemiplegia (muscle and sensory loss on one side of the body), and neuropathy (nerve damage). A record review of Resident 63's admission Minimum Data Set (MDS, comprehensive assessment) dated 6/29/26, indicated Resident 63 had a Brief Interview for Mental Status (BIMS, an assessment of memory and recall ability scored from 00-15), indicated Resident 63 had no memory or recall problems with a score of 15. During an interview on 7/6/26 at 10:10 am, with Resident 63, Resident 63 indicated that, Five days ago one Certified Nursing Assistant [CNA] was rough when getting him up out of bed to the wheelchair. Resident 63 was unable to identify the CNA by name. During an interview on 7/7/26 at 2:28 pm, with Resident 63, Resident 63 was able to describe the alleged rough CNA's hair color and what they wore. Resident 63 expressed concern about receiving care from that CNA. Resident 63 stated he had reported this rough treatment to LN O at the time it happened. Resident 63 indicated that no one followed up with him after he reported the incident. Resident 63 indicated he would be able to identify the alleged CNA, if he saw them again. During an interview on 7/7/26 at 4:03 pm, with the Administrator (ADM), ADM indicated that she was not aware of any reports where Resident 63 had made an abuse allegation of rough treatment by a CNA. During an interview on 7/8/26 at 7:45 am, with LN O, LN O confirmed Resident 63 told him a CNA Was kind of rough when caring for him. LN O indicated he thought he knew who this CNA was, however, Resident 63 did not identify them by name. LN O indicated he did not think this was abuse or suspect abuse because the resident stated, kind of rough. LN O indicated on 7/4/26 at 4:10 pm, he called the Director of Staff Development (DSD) to request the resident be reassigned to another CNA but could not reach them and did not leave a message. LN O indicated he was off for a couple days following the allegation and reporting it slipped his mind. LN O confirmed he did not follow up and should have. During an interview on 7/8/26 at 1:37 pm, with ADM, ADM indicated Resident 63 identified CNA I by a photograph and said they were rough during his care. During an interview on 7/8/26 at 2:41 pm, with the Director of Nursing (DON), DON stated she was notified by the ADM on 7/7/26 of Resident 63's alleged abuse report. DON indicated nurses must report any allegations of abuse within two hours of receiving an allegation. DON indicated LN O should (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have reported the alleged abuse on the day Resident 63 reported it to him to the ADM, CDPH, Ombudsman and local law enforcement immediately or within 2 hours in accordance with the facility's policy.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to ensure a routinely prescribed medication was available and administered as ordered for one of seven sampled residents (Resident 102). This failure placed the resident at risk for worsening gastrointestinal symptoms and pain. Findings: A review of the facility policy titled, Administering Medication, reviewed 10/2025, indicated Policy Interpretation and Implementation 2. Medications are administered in accordance with prescriber orders, including any required time frame. A review of Resident 102's admission Record indicated that she was admitted to the facility on [DATE] with diagnoses that included acute gastritis (stomach lining has suddenly become irritated or inflamed), gastro-esophageal reflux disease without esophagitis (GERD, stomach acid regularly flows back up the tube that carries food from the mouth to the stomach), and chronic pain. A review of Resident 102's Minimum Data Set (MDS, an assessment and care screening tool), dated 6/12/26, indicated that Resident 102 had a brief interview for mental status (BIMS) score of 12 out of 15, at section C Cognitive Patterns indicating she was moderately cognitively impaired. During an interview on 7/6/26 at 12:20 pm, with Resident 102, Resident 102 indicated two days ago she was unable to eat lunch or dinner because her stomach medication wasn't available. Resident 102 indicated the facility was out of Sucralfate (medication that coats and protects the stomach from ulcers and gastric acids), but had not informed her. A review of Resident 102's Physician Order Summary dated 6/5/26, indicated Resident 102 was prescribed Sucralfate, 1 tablet, 1 gram (gm, a unit of measure), give 1 tablet by mouth four times a day for acute gastritis (inflammation of stomach lining), and give on an empty stomach. A review of Resident 102's Medication Administration Record (MAR), from 7/1/26 to 7/7/26, indicated on 7/4/26 that Sucralfate 1 gm, had not been administered at 11 am and 4 pm. A review of Resident 102's Documentation Survey Report, dated 7/1/26 to 7/7/26, indicated that on 7/4/26, Resident 102 had refused breakfast, lunch and supper. During a concurrent interview and record review on 7/8/26 at 1:43 pm, with Licensed Nurse (LN) L, LN L indicated if Sucralfate was administered late then Resident 102 will refuse to eat due to stomach discomfort. LN L indicated Resident 102 has told LN L that she can't eat if she does not have her Sucralfate given to her on an empty stomach before meals. LN L confirmed that on 7/4/26 the 11 am and 4 pm doses of Sucralfate were not given to Resident 102, because the medication was not available. LN L stated when the facility has ran out of a resident's medication the nurse was to call the pharmacy and reorder the medication and notify the resident and their physician. LN L confirmed that on 7/4/26, Resident 102's Sucralfate was reordered late. LN L indicated the standard practice would have been to reorder Resident 102's Sucralfate when there were about five left.		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observations, interviews, and record review, the facility failed to ensure two of 19 kitchen employees demonstrated the competency and skills necessary to safely perform daily kitchen duties when:1. Proper hand hygiene was not performed.2. Cross contamination was observed during food prep.3. Resident menus and recipes were not followed.4. Temperatures were not properly taken for tray line.This failure had the potential to result in unsafe food handling practices, increasing the risk of food contamination and foodborne illness for 118 residents who received food prepared in the kitchen.Findings:During a review of the facility Diet Order Tally Report, dated 7/7/26, the report indicated that 118 residents received food prepared in the kitchen, including four residents receiving puree diets.During a review of the facility cook's (FC) employee file, signed by the FC , undated, the [NAME] Job Description, indicated, the cook is responsible for maintaining a safe, clean, and sanitary kitchen; preparing meals according to the menu and portion control guidelines; recording meal temperatures; preparing puree foods; and cleaning cooking and serving areas.During a review of the FC's employee file, signed by the Registered Dietician (RD) and FC, dated 2/3/26, indicated the FC met the standard for hand washing, glove use, use of recipes, cutting board use, and recording temperature for tray line.During a review of the FC's employee file, signed by the FC, dated 4/30/26, the Employee Disciplinary Action Form, indicated, the FC had received disciplinary action for failing to follow a resident specific diet. The corrective action plan required 0 discrepancies related to diet and liquid consistency orders, less than 5 percent (%) error for food preferences, and 100% tray line compliance for 90 consecutive days.During a review of the Dietary Aide's (DA) employee file, signed by the DA, dated 9/25/25, the Dietary Aide Job Description, indicated, the dietary aid is responsible for learning food service procedures, setting up meal trays, preparing snacks and nourishments, maintaining a clean and sanitary kitchen, and assisting the cook or dietary supervisor as needed.During a review of the DA's employee file, signed by the RD and DA, dated 2026, titled, Food and Nutrition Competency Checklist - Food Service Worker indicated the DA met the standard for safety precautions, infection control practices, hand washing, glove use, and knowledge of food practices.1. During a review of the facility's policy and procedure (P&P) titled, Glove Use Policy, dated 2023, indicated, that hands must be washed before applying gloves and before donning a new pair. Gloves must be changed between tasks, after handling raw meat, when torn or soiled, after potential contamination, and at least every four hours during continual use.During a review of the facility's P&P titled, Hand Washing Procedure, dated 10/2026, indicated, that hand washing is essential to prevent he spread of infection and should be performed using soap and warm water before beginning work in the kitchen, before and after handing food, after handling soiled dishes and utensils, and after touching a trash can or its lid.During a review of the facility document titled, Food and Nutrition Service In-Service - Topic - Norovirus, Hand washing/Glove Use, dated 1/13/26, indicated the FC attendrd the in-service, but the DA did not.During an observation on 7/7/26 at 10:05 am, in the kitchen during food preparation, the FC was observed removing gloves and donning a new pair on four separate occasions, without washing his hands between glove changes.During an observation on 7/7/26 at 10:33 am, and again at 11:55 am, in the kitchen during food preparation, the DA was observed removing gloves, touching the trash can, and donning a new pair of gloves, without washing her hands between glove changes.2. During a review of the facility's P&P titled, Food Handling, dated 2023, indicated, that food must be prepared and served in a safe and sanitary manner, personnel must wash their hands before handling food and before and after handling raw meat, bare-hand contact with (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Arbor Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	food is prohibited, gloves must be changed before handling washed or ready to eat food items, and suitable utensils or single use gloves must be used when handling food. During a review of the facility document titled, Food and Nutrition Service In-Service - Topic - Food Preferences, Allergies, Mock Survey, dated 4/10/26, indicated the in-service included prevention of cross contamination during food preparation and food service. Documentation indicated FC attended the in-service. During an observation on 7/7/26 at 10:15 am, in the kitchen during food preparation, the FC was observed preparing food on a countertop that appeared unclean, was cluttered, and had the presence of food crumbs. On two occasions the FC was observed returning cooked meat to the cutting board after touching the meat to a portion guide mounted on the wall. During food preparation, the FC was observed flipping the cutting board over and continuing food preparation after the opposite side of the cutting board had been in contact with the countertop surface. The FC was observed going to the dish machine (dishwasher) and returning to the food preparation area without washing their hands. The FC was observed pulling aluminum foil from the box, folding it against his clothing before using it to cover vegetables, and touching the scale controls before handling cooked zucchini with the same gloved hand. During an observation on 7/7/26 at 11:45 am, in the kitchen during tray line, the FC was observed touching his face and continuing to serve food without changing gloves or performing hand hygiene. 3. During a review of the facility's P&P titled, Portion Control, dated 2025, indicated, that food must be portioned according to the menu using the appropriate portion-control equipment. The policy specified that scoop sizes are identified by number and listed in the menu recipe books and menu spreadsheet, and that staff are to use the designated portion-control equipment when serving food. During review of the facility recipe titled, Recipe: Pureed (IDDSI Level #4) Vegetables, dated 2025, indicated, Vegetables were to be pureed to a paste consistency before adding liquid. Warm low-sodium (salt) broth or milk was to be added gradually only if needed, and thickener was to be added after pureeing to achieve the appropriate consistency. During review of the facility recipe titled, Recipe: Pureed (IDDSI Level #4) Casserole (which was used for the chicken), dated 2025, indicated, vegetables are to be pureed to a paste consistency before adding liquid. Warm low-sodium broth or milk was to be added gradually only if needed, and thickener was to be added after pureeing to achieve the appropriate consistency. During a review of the facility document titled, Food and Nutrition Service In-Service - Topic - IDDSI, Diets, Liquid, Texture testing methods, dated 9/15/25, indicated the FC did not attend the in-service. During an observation on 7/7/26 at 10:05 am, in the kitchen during food preparation, the FC was observed preparing pureed Italian chicken using broth that was not low-sodium. The FC added an unmeasured amount of the broth until it reached puree consistency. During an observation on 7/7/26 at 10:15 am, in the kitchen during food preparation, the FC was observed preparing pureed zucchini using broth that was not low-sodium. The FC added the broth before blending the vegetables, after which thickener was added to achieve the appropriate consistency. During review of the facility menu titled, Summer Menus, dated 7/7/26, indicated, the soft and bite size baked zucchini was to be served as a 1/2 cup (#8 scoop) portion for the regular diet. During an observation on 7/7/26 at 11:50 am, in the kitchen during tray line, the FC was observed using a 1/3 cup (#12 scoop) to serve the soft and bite size baked zucchini for the regular diet, instead of the 1/2 cup (#8 scoop) specified on the menu. During an interview 7/9/26 at 11:06 am, with the facility Dietary Manager (DM), the DM confirmed that the bite size zucchini for the regular diet was served using a 1/3 cup (#12 scoop), instead of the 1/2 cup (#8 scoop) specified on the menu. 4. According to the USDA Food Code 2022, Section 4-302.12 Food Temperature Measuring Devices, the presence and accessibility of food temperature measuring devices is critical to the effective monitoring of food temperatures. Proper use of such devices provides the operator or person in (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Arbor Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 Springfield Drive Chico, CA 95928	
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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	charge with important information with which to determine if temperatures should be adjusted or if foods should be discarded. Review of a professional reference article titled, CDPH Reminds Californians about Safe Food Handling During Summer Season, dated 6/29/17, indicated, safety tips for properly preparing and handling food: Measure the temperature in the thickest part of the food, ensuring the thermometer does not touch bone or the cooking pan which can give you an inaccurate reading. https://www.cdph.ca.gov/Programs/OPA/Pages/NR17-056.aspx During a review of the facility's P&P titled, Meal Service, dated 2023, indicated, that meals are to be served at the appropriate temperature and that food and nutrition services staff are to verify food temperatures prior to meal service using a cleaned and sanitized thermometer inserted into the thickest part of the food to ensure an accurate temperature reading. During a review of the facility document titled, Food and Nutrition Service In-Service - Topic - Handwashing, Survey Prep, and Temperatures, dated 7/1/26, indicated the FC did attend the in-service. During an observation on 7/7/26 at 11:37 am, in the kitchen during tray line, the FC was observed taking the temperature of food prepared for serving with the thermometer probe inserted until the tip contacted the hot bottom and side of the food container rather than positioned within the food. During an interview on 7/8/26 at 9:21 am, with the Registered Dietician (RD), the RD confirmed recipes are expected to be followed, including using low-sodium broth as specified and adding liquid to pureed vegetables only after the vegetables have been pureed, if needed. The RD confirmed kitchen staff are expected to perform proper hand hygiene between glove changes and after touching contaminants, such as trash or the face. The RD further confirmed that using a cluttered food preparation service, flipping a cutting board after it had contacted the soiled countertop and continuing food preparation, and returning food to the cutting board after it had contacted a size reference guide posted on the wall were all examples of cross contamination. The RD indicated employee competency is evaluated following in-services through verbal responses or direct observation of task performance. The RD also confirmed that a thermometer probe should be inserted into the thickest part of the food and should not contact the hot bottom or sides of the food container while obtaining a food temperature.		