

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555383	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2025
NAME OF PROVIDER OR SUPPLIER Blythe Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 285 West Chanslor Way Blythe, CA 92225	

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)
<p>F 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of four Certified Nursing Assistants reviewed (CNA 1) maintained an active State-approved CNA certification and current CPR certification (cardiopulmonary resuscitation - an emergency lifesaving procedure performed when the heart stops beating) before providing direct care to residents. This failure had the potential to result in unsafe and inadequate care to residents. Findings:A review of CNA 1's Employee file indicated, CNA 1's license was issued on [DATE], and expired on [DATE].A further review of CNA 1's employee file indicated no documentation of a current CPR certificate. A review of facility's Staffing Assignment dated [DATE] and [DATE], indicated CNA 1 was scheduled to work on both dates.On [DATE], at 3:50 p.m., a concurrent interview and record review of staffing schedule and employee personnel file was conducted with the Director of Staff Development (DSD). The DSD stated she assists with the facility's hiring process and is responsible for verifying staff employment requirements, including current and active licenses and CPR certificates. The DSD stated, CNA 1 worked the morning shift on [DATE], and the night shift on [DATE], and stated she should not have been scheduled. The DSD further stated, CNA 1 should not have been placed on the schedule without an active license and CPR certification, as this created the potential for not being able to provide adequate care to residents. On [DATE], at 4:31 p.m., a concurrent interview and record review of staffing schedule and CNA 1's employee personnel file was conducted with the DON. The DON stated CNAs are required to have an active license and CPR certification to provide direct care to residents. The DON stated, CNA 1 was on the schedule on [DATE], and [DATE], despite her expired CNA license and lacking a CPR certificate. The DON stated her expectations was for all staff to keep their licenses up to date and for the DSD to follow up. The DON stated it was an oversight and CNA 1 should not have been allowed to work without a current license due to a potential in not being able to deliver safe and adequate care to residents.A review of facility's policy and procedure titled Hiring, dated [DATE], indicated, .This facility provides an equal employment opportunity to all person qualified to perform the essential functions of the position that is to be filled.the following criteria will be considered in determining whether an applicant is qualified for a particular job positions.skill, knowledge, training, efficiency, etc.; and certification and licenses.A review of the facility's job description, titled Position Description: Certified Nursing Assistant, dated [DATE], indicated, .minimum qualification requirements.education.current, active, California Nursing Assistant Certification.A review of the facility's job description, titled Position Description: Director of Staff Development, dated [DATE], indicated, . detailed duties and responsibilities, essential functions.assist and tracks CNA staff in renewal of required State certification.</p>

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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