STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555383	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blythe Post Acute LLC	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive care plan was developed for one of one resident reviewed for tobacco use (Resident 1) following her re-admission to the facility, despite a documented history of marijuana use. This failure had the potential to place the resident at risk for adverse health effects related to medical diagnoses, unsafe use or storage of marijuana, and smoke-related safety hazards. Findings:On June 10, 2025, Resident 1's admission record was reviewed. Resident 1 was initially admitted on [DATE] and re-admitted on [DATE], with diagnoses which included heart failure (when the heart doesn't pump blood effectively), chronic obstructive pulmonary disease (lung disease) and nicotine dependence (smoker). Resident 1 had a history of marijuana use while in the facility.A review of Resident 1's History and Physical, dated June 22, 2025, indicated Resident 1 had the capacity to understand and make decisions.A review of Resident 1's Minimum Data Set (MDS - an assessment tool), dated June 24, 2025, indicated Resident 1 had Brief Interview of Mental Status (BIMS - a tool to assess cognitive function of an individual) score of 15 (intact cognitive response).A review of Resident 1's previous Short Term Goals care plans, dated October 31, 2024, indicated resident had a positive test for THC (Tetrahydrocannabinol ingredient in marijuana).A further review of Resident 1's care plan indicated no interventions addressing marijuana use being identified in the admission history. On July 10, 2025, at 11:06 a.m., a concurrent observation and interview was conducted with Resident 1. Resident 1 was sitting in her wheelchair in her room and was receiving 2L (liters) of oxygen via nasal canula (tubing that delivers oxygen into nostril). Resident 1 stated she was a smoker and did not need supervision. Resident 1 stated she needed oxygen sometimes because she had difficulty breathing. On July 10, 2025, at 2:12 p.m., a concurrent interview and record review of Resident 1's care plans were conducted with the Registered Nurse (RN). The RN stated Resident 1 was re-admitted to the facility on [DATE] and should have new set of care plans developed for her specific needs and should be available in her records. The RN stated Resident 1 was a smoker and had previous history of testing positive for THC. The RN verified and stated there was no smoking care plan available in Resident 1's current records. The RN stated Resident 1 should have a care plan to ensure she remained safe and was not continuing to smoke marijuana to prevent any health risks due to her health history.On July 10, 2025, at 3:35 p.m., a concurrent interview and record review of Resident 1's care plans were conducted with the Director of Nursing (DON). The DON stated she was responsible for conducting assessments and developing care plans for residents. The DON stated for newly or re-admitted residents, a set of new care plans should be implemented to address their conditions and specific needs. The DON stated Resident 1 was sent out to the hospital and returned back to facility on June 17, 2025. The DON verified and stated Resident 1 did not have a smoking care plan in her current records. The DON stated Resident 1 was a smoker and had previously tested positive for THC. The DON stated, Resident 1 should have a smoking care plan to avoid safety related risks and ensure the resident was following facility rules of not continuing to smoke marijuana and further compromise her health.A review of the facility's policy and procedure titled, Care Plans, Comprehensive, dated 2016, indicated .a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet resident's physical, psychosocial and functional needs is developed and implemented for each resident.the comprehensive, person-centered care plan is developed within seven (7) days of the completion of required comprehensive assessment (MDS). assessment of residents are ongoing and care plans are revised as information about the residents and residents' conditions change.the Interdisciplinary Team must review and update the care plan.when the resident has been readmitted to the facility from a hospital stay.